MANAGED CARE
ANNUAL STATISTICAL REPORT

Published April 2001

Internet Homepage - http://www.dhs.ca.gov/MCSS

The Managed Care Annual Statistical Report provides information about the medical managed care programs rendering care to Medi-Cal beneficiaries. It provides information on the number of persons enrolled in managed care, and a description of some of the demographic and eligibility characteristics of this population.

Prepared by the Department of Health Services.

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MANAGED CARE ANNUAL STATISTICAL REPORT

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Introduction

The Managed Care Annual Statistical Report provides information about the medical managed care programs rendering care to Medi-Cal eligibles. It provides a description of the types of programs providing managed care services to Medi-Cal beneficiaries, the number of persons enrolled, and a description of some of the demographic and eligibility characteristics of this population.[1]

The Managed Care Annual Statistical Report does not provide cost or utilization information for the Medi-Cal managed care population. Cost data for this population as well as those in fee-for-service are available in the Annual Statistical Report issued by this Section. Managed care utilization information is currently limited but will become available at a future date from the State Department of Health Services (DHS). Detailed information about dental managed care can be obtained from the DHS Payment Systems Division, Office of Medi-Cal Dental Services.

This report is comprised of three Sections, each of which describes the managed care program and its population in the broader context of the whole medical Medi-Cal program. These Sections are: 1) history and description, including current enrollment data; 2) demographic characteristics; and, 3) eligibility continuity and rate of new eligibles.

Section 1, History and Description of Medi-Cal Managed Care

Until 1995, Medi-Cal had predominately used a fee-for-service (FFS) health care delivery system to provide care to its beneficiary population. Under this system, qualified providers render care or provide drugs, durable medical equipment (DME) items, etc. to beneficiaries, then bill the State; upon adjudication of their claims for services, the providers are paid the Medi-Cal allowed amount.

Managed care is a planned, comprehensive approach to the provision of health care combining clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in an effective manner. Under managed care, individual providers are linked together into a system that formalizes the often informal provider relationships that exist under fee-for-service (FFS) and brings them together under a single entity, the managed care plan. The plan manages the linkages and is accountable for performance and outcomes. Managed care's emphasis on access to primary care is intended to increase utilization of clinical preventive services and thus reduce both the unnecessary use of emergency rooms for ambulatory care and preventable hospitalizations. In turn, this enables the plan to reallocate its resources to promote preventive and primary care for its members.

[1] The terms “eligible,” “beneficiary,” and “enrollee” are used interchangeably within Medi-Cal. Each refers to a person who meets all requirements for receiving a Medi-Cal medical service or good (e.g., drugs, DME items) and is enrolled in the Medi-Cal program. These terms are differentiated from the term “user,” who instead is an eligible/beneficiary/enrollee actually receiving a service or needing a drug, DME item, etc.

Section 1.1, History of Medi-Cal Managed Care

Medi-Cal began covering eligible beneficiaries in March 1966. In May 1972 Medi-Cal beneficiaries began enrolling in managed care plans when the first Prepaid Health Plan (PHP) contract went into effect. Joining a PHP was voluntary, and limited to those in a public assistance aid category. In June 1983, a new type of managed care program, the County Organized Health System (COHS), began covering Medi-Cal beneficiaries when the Monterey Health Initiative became operational. This program stressed case management and utilization control in the delivery of health services to Medi-Cal eligibles. A few months later, in September 1983, the Santa Barbara Health Initiative began operating a COHS in that county. Both were similar in that almost all beneficiaries in the county were mandated to join the plan. Whereas the Monterey program stressed local control Primary Care Case Management, Santa Barbara stressed centralized utilization control. The Monterey COHS ceased operations in July 1985. In December 1987, a third COHS, the Health Plan of San Mateo, began operating.

In August 1984, a third Medi-Cal managed care program began operation, the Primary Care Case Management (PCCM) program. Enrollment in PCCM plans was voluntary, like the PHP program. The PCCM's were responsible for outpatient services only. Inpatient services for PCCM enrollees were delivered through the FFS program. The PCCM stressed assignment of a personal physician to each beneficiary in the plan, and that physician authorized virtually all other services delivered by the PCCM plan.

State legislation in 1991 and 1992 enabled a substantial expansion of Medi-Cal managed care, primarily for AFDC-linked eligibles.[2] Pursuant to this legislation, the Department of Health Services (DHS) started the process of developing and implementing a Geographic Managed Care program in two counties, a Two-Plan Model program in twelve counties, and the COHS program in three additional counties. (See Appendix, Table A.1 for a list of the aid categories each of these plans cover.) In addition, a Medi-Cal Fee-for-Service Managed Care Program began in the counties of Sonoma and Placer in March and October 1997, respectively. This program involves paying the contracted local government a fee per eligible per month for: 1) establishing a primary care physician network from which beneficiaries select or are assigned to a personal physician; and 2) case managing the services received by the Medi-Cal beneficiaries

The 1991 managed care legislation was significant in that prior to 1991 in a county in which Medi-Cal managed care plan enrollment was available, beneficiaries who did not select between FFS and a plan were defaulted into FFS. With the 1991 legislation, the state was allowed under specific circumstances to direct the defaults into managed care.

[2] The term Aid to Families with Dependent Children, or AFDC, is being replaced by other terms and programs, pursuant to recent Federal and State legislation. For example, some persons formerly eligible under AFDC have become eligible under California's CalWorks' program, which implements the "Federal Temporary Assistance to Needy Families" (TANF) program. Other formerly AFDC eligibles are referred to as eligibles under Section l93lb of Title XIX of the Social Security Act.

Section 1.2, Description of Medi-Cal Managed Care

Before 1994, there were three managed care programs providing medical care to the Medi-Cal population, the Prepaid Health Plan program, Primary Care Case Management program, and the County Organized Health System program. From 1994 forward, two more programs were developed and implemented, the Geographic Managed Care program and the Two Plan Model program. In 1995 and 1996, three additional counties formed COHS organizations. Currently, there are five managed care programs enrolling Medi-Cal eligibles: Prepaid Health Plans (full capitation, voluntary), Primary Care Case Management plans (inpatient services excluded, voluntary), County Organized Health Systems (most aid categories, mandatory), Geographic Managed Care plans (CalWORKs-linked, mandatory) and Two-Plan Model plans (CalWORKs-linked, mandatory). The following describe each of these programs.

Prepaid Health Plan

The State Waxman-Duffy Act authorized HMO contracting in the Medi-Cal Program and referred to such plans as Prepaid Health Plans (PHPs). In California, the PHP contracting program was established as an alternative to FFS. The intent of the program was to provide the CalWORKs-linked Medi-Cal beneficiaries who enrolled to have access to health care generally available in the public sector. PHPs are required to provide, on a capitated, at-risk basis, all basic Medi-Cal covered benefits, excluding such specified treatments as major organ transplants, chronic renal dialysis and long term care. (Refer to Appendix, Table A.1 for a complete list of aid categories and their classifications.) In addition, PHPs operating under managed care principles provide case management, preventive and health maintenance services. As managed care contractors, PHPs have other requirements not found in FFS, such as quality of care, membership services, and member grievance procedures. DHS administers the contracts with the PHP contractors. The Department of Managed Health Care oversees their operations as commercial health plans under the Knox-Keene Act. As of June 2000 beneficiaries in PHP's comprise 0.02% of all Medi-Cal beneficiaries, or about 950 members per month.

Primary Care Case Management

The Primary Care Case Management (PCCM) program is a managed care model that covers outpatient, physician, and some other outpatient services. PCCMs exclude inpatient services and some outpatient services from the scope of benefits provided under their capitated contracts.

Under PCCM arrangements, primary care providers contract with DHS as managed care plans to provide and assume risk for primary care and specialty physicians' services as well as selected outpatient preventive and treatment services; inpatient services are excluded. (Refer to Appendix, Table A.1 for a complete list of aid categories and their classifications.) PCCM contractors are required to case manage all services provided to their enrollees. Contractors participate in program savings through savings-sharing agreements with DHS. Shared savings must be produced by the PCCM's effective case management of services for which the PCCM is not at-risk, the most significant of which is inpatient hospital care.

PCCM contracts operate under DHS' review and oversight. Although PCCMs have not been directly subject to either the Knox-Keene or Waxman-Duffy Prepaid Health Plan Act, many of the relevant requirements are reflected in these contracts. Due to the implementation of the mandatory managed care programs, only a few PCCMs remain in operation. As of June 2000 beneficiaries in PCCM's comprise 0.03% of all Medi-Cal beneficiaries, or about 1,290 members per month.

Geographic Managed Care

Sacramento County was selected for the development of a Geographic Managed Care (GMC) program in early 1992, and was started April 1994. Under Sacramento GMC, DHS contracts with seven managed care health plans for medical services and four dental care plans for dental services. The California Medical Assistance Commission negotiates capitation rates with each plan; rates are kept confidential. The mandatory aid category groups are: CalWORKs, Medically Needy with no share of cost, Medically Indigent Adult (confirmed pregnancy), and Medically Indigent children (Refer to Appendix, Table A.1 for a complete list of aid categories and their classification.) Medi-Cal beneficiaries allowed to join voluntarily include those who are in an SSI or foster child aid category or who otherwise meet certain medical exemption criteria. Beneficiaries enrolled with a commercial or Medicare HMO are not allowed to enroll. In addition, eligibles in a mandatory aid category will not be in a plan during the months they are retroactively eligible for Medi-Cal, or for the first two months of their eligibility, during which they decide which plan to belong to.

DHS received waivers of federal requirements for freedom of choice that permitted provision of Medi-Cal benefits to this population exclusively through GMC managed care plans. State legislation in 1994 permitted a second GMC program, called "Healthy San Diego," to be formed in San Diego county and was completed in mid-1998.

Under GMC, covered beneficiaries are informed about the available managed care plans and then are asked to select a plan to join. Beneficiaries are assisted in the selection process through the involvement of a Health Care Options (HCO) contractor, who provides them a presentation and explanatory materials. If a beneficiary does not select a plan, he/she is assigned to a plan.

Initially, five of the seven Sacramento GMC plans were fully-capitated PHP plans and two were PCCMs. Currently, there are seven comprehensive plans in Sacramento county and seven in San Diego county that cover inpatient and all other medical services. DHS directly contracts with each of these GMC plans. As of June 2000 beneficiaries in GMC's comprise 6.15% of all Medi-Cal beneficiaries, or about 311,150 members per month.

County Organized Health Systems

Under the County Organized Health System (COHS) model, a local agency, with representation from providers, beneficiaries, local government, and other interested parties, is created by a county board of supervisors to contract with the Medi-Cal program. Operating under federal Medicaid freedom of choice and other waivers, the COHS administers a capitated, comprehensive, case managed health care delivery system. The COHS has the responsibility for utilization control and claims administration, and must provide most Medi-Cal covered health care services. In contrast to PHPs and PCCMs, COHSs are health insuring organizations which manage and pay for services, but do not directly provide care. Virtually all Medi-Cal beneficiaries with legal residency in the county must belong to the COHS. (Medi-Cal beneficiaries who are in recently established aid categories may not be covered due to a lack of historical data upon which to establish capitation rates.) Beneficiaries are given a wide choice of providers but do not have the option of obtaining Medi-Cal services under the traditional fee-for-service system except for those services excluded from being covered by the COHS plan, e.g., long term care (some plans only). Like the GMC program, capitation rates for each plan are negotiated by the California Medical Assistance Commission; rates are kept confidential.

COHSs currently exist in Monterey, Napa, Orange, San Mateo, Santa Barbara, Santa Cruz, Solano and Yolo counties.

Three COHSs operated in the 1980's, in the counties of Monterey, Santa Barbara, and San Mateo. Monterey ceased operations in 1985. Enabling State legislation and federal HCFA waiver approvals later permitted three additional counties to form County Organized Health Systems. The Solano Partnership Health Plan began operations in May 1994 and became Partnership Health Plan of California in March 1998, when Napa county was added. In October 1995, the California Orange Prevention and Treatment Integrated Medical Assistance Plan (CalOPTIMA) started enrolling Medical beneficiaries. In January 1996, the Santa Cruz County Health Options began operations; when Monterey county joined Santa Cruz in October 1999, the plan changed its name to Central Coast Alliance for Health. As of June 2000 beneficiaries in COHS's comprise 7.93% of all Medi-Cal beneficiaries, or about 401,560 members per month.

Two-Plan Model

A plan for a new type of Medi-Cal managed care program was developed by DHS and issued March 31, l993 under the title Expanding Medi-Cal Managed Care. Under this program, two HMO plans operate in each of the selected counties. One is operated under the auspices of the county government or a community based entity, e.g., an independent health commission; the other is a commercial HMO selected by DHS through competitive bid. The two plans are directly monitored by DHS and have the same contract requirements. The publicly-sponsored plan is referred to as the local initiative (LI), and the private HMO as the commercial plan (CP). It was envisioned that the LI would provide a means for hospitals, clinics, and physicians who traditionally cared for Medi-Cal beneficiaries under fee-for-service, as well as the safety net providers who provide care to both Medi-Cal beneficiaries and other medically indigent persons, to continue providing these services under managed care. In the case of hospitals, this arrangement helps support receipt of federal disproportionate share hospital funds. Contract

provisions also promote use of cultural and linguistic services for those needing them. Both the LI and CP plans provide full medical services, including inpatient, and must be Knox-Keene licensed. Contract rates are established by DHS.

The mandatory aid category groups are: CalWORKs, Medically Needy with no share of cost, Medically Indigent Adult (confirmed pregnancy), and Medically Indigent children. (Refer to Appendix, Table A.1 for a complete list of aid categories and their classification.) Those allowed to join voluntarily include those who are in an SSI or foster child aid category or who meet certain medical exemption criteria.

The counties selected by DHS for the Two Plan Model were initially Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Subsequently, San Diego was legislatively chosen to implement the GMC program (see above), and Fresno chose not to implement a local initiative, thereby resulting in DHS selecting a second commercial plan for that county. As of June 2000 beneficiaries in Two-Plan model plans comprise 35.18% of all Medi-Cal beneficiaries, or about 1,781,180 members per month.

Special Projects

DHS is developing new types of managed care programs Medi-Cal beneficiaries. These managed care programs strive to promote improved health status and to avoid non-duplicative or otherwise unnecessary costs. Two types of special projects currently implemented in DHS are:

Medical Case Management of High Cost Beneficiaries -- DHS has established other programs to manage high-cost Medi-Cal beneficiaries within the fee-for-service (FFS) environment. Under this program, DHS develops and conducts pilot projects under which these populations receive medical case management. Examples of this population include those with AIDS and the elderly, e.g., On Lok and Scan Health plans

Fee-For-Service Managed Care -- To improve the coordination of care for those beneficiaries in FFS and to improve continuity of care, DHS established fee-for-service, “gatekeeper model” managed care programs in Sonoma and Placer Counties, starting March and October 1997, respectively. (San Luis Obispo is in the planning stages.) Under this program, DHS enrolls beneficiaries with primary care providers for medical case management, thereby improving coordination of care and lowering costs.

As of June 2000 beneficiaries in Special Projects comprise 0.04% of all Medi-Cal beneficiaries, or about 2,060 members per month.

Scope of Services Covered by Managed Care

The scope of services covered by Medi-Cal managed care health plans is determined by their contract with DHS. Comprehensive plans typically cover inpatient care, limited skilled nursing services, and most outpatient services. Exceptions may vary from plan to plan and between managed care models. Plans are required, for services they must cover, to provide all medically necessary care, but may restrict such coverage to no more than what the Medi-Cal Program would cover or may expand the coverage provided.

Section 1.3, Current Enrollment Data

Table 1.1A, Medi-Cal Eligibles by Program - Fee-For-Service vs. Managed Care

The following graph shows the monthly enrollment in Medi-Cal for medical fee-for-service and managed care, from 1998 forward.

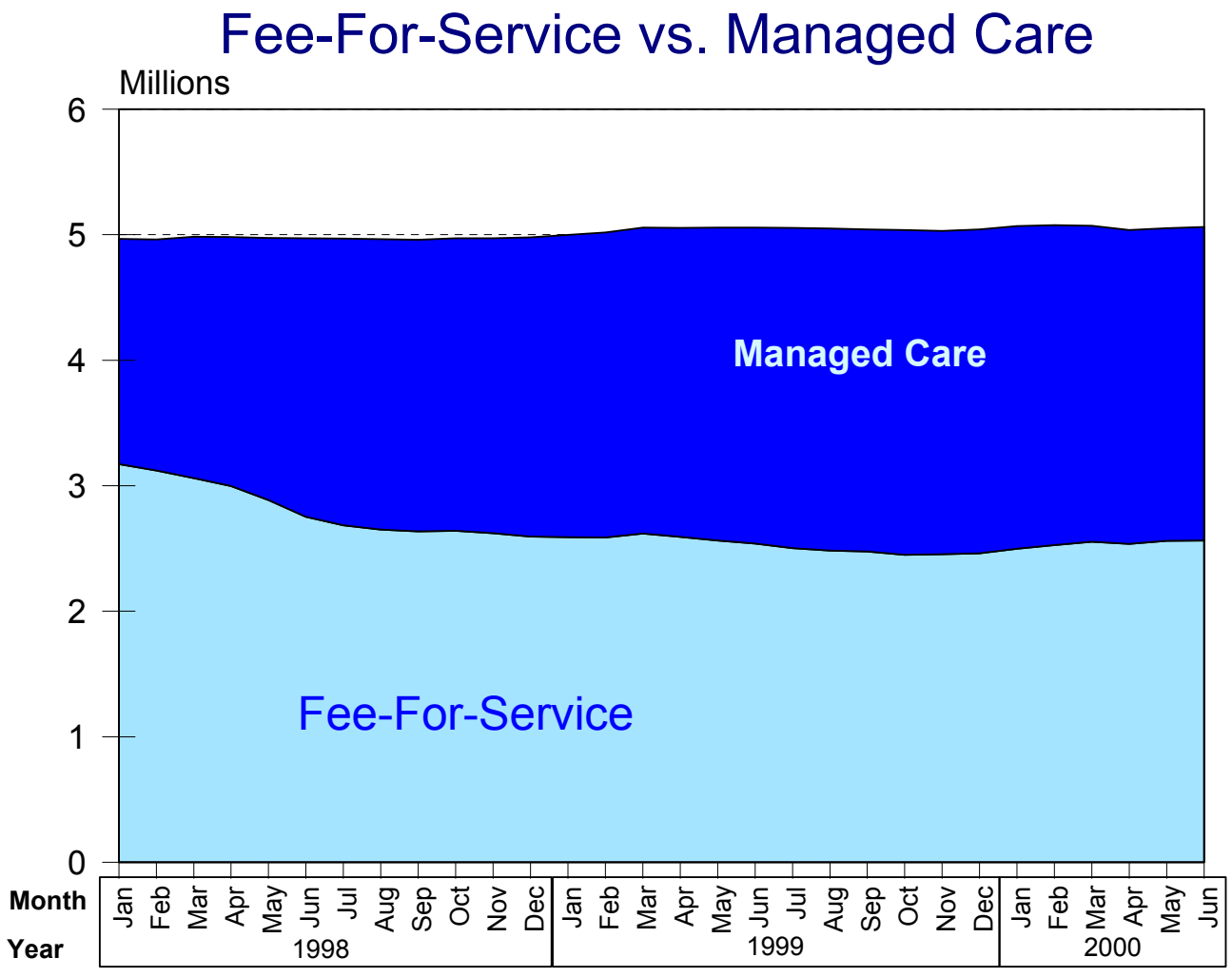


Table 1.1B, Medi-Cal Eligibles by Program -Managed Care Programs

FFS-covered eligibles are excluded from this graph. Each type of managed care program is shown separately. Total June 2000 enrollment was: COHS – 401,558; GMC – 311,145; Two-Plan/Local Initiative – 1,092,732; Two-Plan/Commercial Plan – 688,450; PCCM – 1,288; PHP – 948.

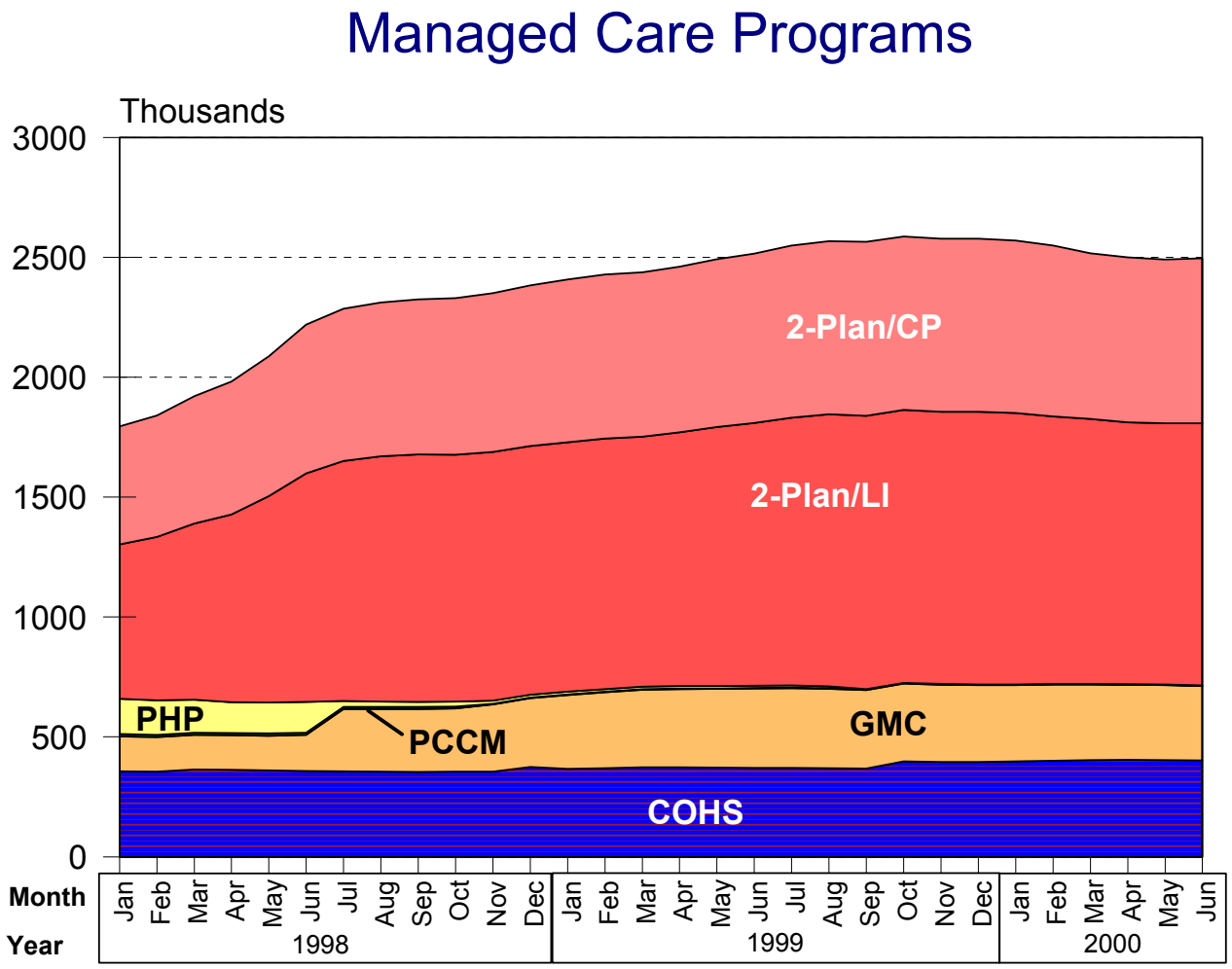


Table 1.2, Map of California's Managed Care Counties

The following map of California shows each county with a managed care plan in operation.

(Note: Excludes PHP and PCCM programs.)

Click here to view Table 1.2 Map.

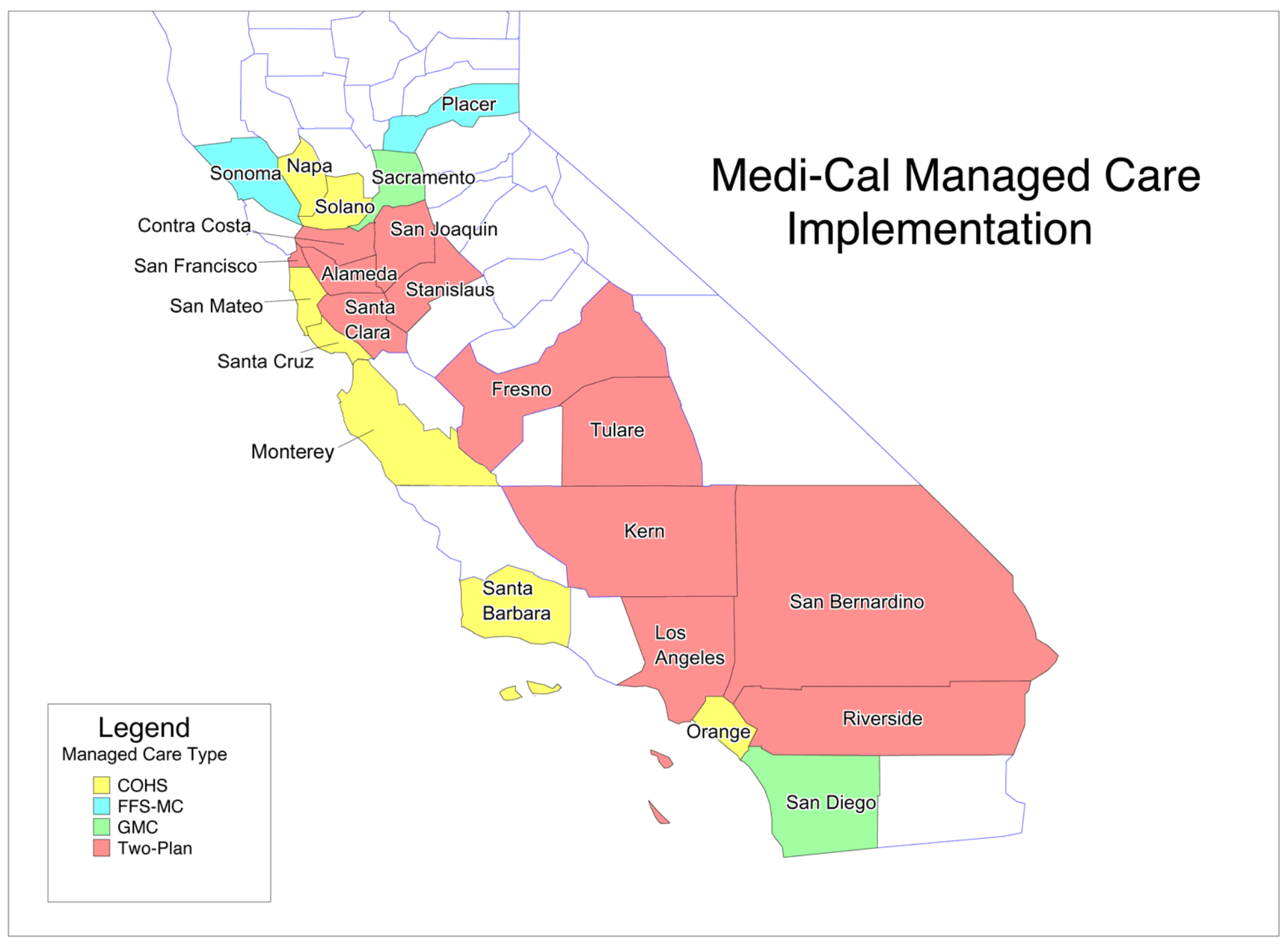

Medi-Cal Managed Care Implementation
Placer
Sonoma
Napa
Sacramento
Solano
Contra Costa
San Joaquin
San Francisco
Alameda
Stanislaus
San Mateo
Santa Clara
Santa Cruz
Fresno
Tulare
Monterey
Kern
Santa Barbara
San Bernardino
Los Angeles
Riverside
Orange
San Diego
Legend
Managed Care Type
COHS
FFS-MC
GMC
Two-Plan

Table 1.3, Major Managed Care Plans, by County

The following table shows Medi-Cal managed care plans by county. The managed care programs covered are: County Organized Health Systems (COHS), Fee-For-Service Managed Care Network (FFS-MCN), Geographic Managed Care (GMC), and Two-Plan. Excluded are Prepaid Health Plan (PHP), Primary Care Case Management (PCCM), and special projects (e.g., AIDS, SCAN).

Click here to view Table 1.3A

Table 1.3A, Major Managed Care Plans by County

County	Program	LI/ CP	Plan Name	Start Date	Enrollment* as of July 2000
Alameda	2-PLAN	LI	Alameda Alliance for Health	1/96	71,920
		CP	Blue Cross of California	7/96	27,830
Contra Costa	2-PLAN	LI	Contra Costa Health Plan	2/97	38,277
		CP	Blue Cross of California	6/98	4,823
Fresno	2-PLAN	CP	Health Net	1/97	106,509
		CP	Blue Cross of California	11/96	23,416
Kern	2-PLAN	LI	Kern Health Systems	7/96	48,162
		CP	Blue Cross of California	9/96	27,269
Los Angeles	2-PLAN	LI	LA Care Health Plan	4/97	586,960
		CP	Health Net	7/97	389,783
Monterey	COHS		Central Coast Alliance For Health	10/99	43,019
Napa	COHS		Partnership Health Plan of Calif.	3/98	7,923
Orange	COHS		CalOPTIMA	10/95	218,649
Placer	FFS/MCN**		Placer County Managed Care Network	10/97	10,674
Riverside	2-PLAN	LI	Inland Empire Health Plan	9/96	74,396
		CP	Molina Medical Centers	3/98	22,926
Sacramento	GMC		Blue Cross of California	4/94	57,274
			Health Net	5/96	26,576
			Kaiser Foundation	4/94	19,565
			Maxicare	6/98	19,302
			Blue Cross of California (formerly OMNI)	4/94	15,728
			Western Health Advantage	5/97	15,295
			Molina Healthcare	2/00	1,806
San Bernardino	2-PLAN	LI	Inland Empire Health Plan	9/96	102,332
		CP	Molina Medical Centers	3/98	31,322

Table 1.3A, Major Managed Care Plans by County (continued)

County	Program	LI/ CP	Plan Name	Start Date	Enrollment* as of July 2000
San Diego	GMC***		Blue Cross of California	7/98	10,564
			Community Health Group	7/98	63,942
			Health Net	7/98	6,583
			Kaiser Foundation	7/98	7,812
			Sharp Health Plan	7/98	42,480
			UCSD Healthcare	7/98	11,934
			Universal Care	7/98	10,951
San Francisco	2-PLAN	LI	San Francisco Health Plan	1/97	22,870
		CP	Blue Cross of California	7/96	14,628
San Joaquin	2-PLAN	LI	Health Plan of San Joaquin	2/96	48,288
		CP	OMNI Healthcare (thru 9/99)	1/97	11,781
San Mateo	COHS		Health Plan of San Mateo	12/87	37,707
Santa Barbara	COHS		Santa Barbara Regional Health Authority	9/83	40,753
Santa Clara	2-PLAN	LI	Santa Clara Family Health Plan	2/97	36,967
		CP	Blue Cross of California	10/96	23,036
Santa Cruz	COHS		Central Coast Alliance for Health	1/96	21,225
Solano	COHS		Partnership Health Plan of Calif.	5/94	39,935
Sonoma	FFS/MCN**		Sonoma County Managed Care Network	3/97	24,619
Stanislaus	2-PLAN	LI	Blue Cross of California/SLI	10/97	33,314
		CP	OMNI Healthcare (thru 2/00)	2/97	0
Tulare	2-PLAN	LI	Blue Cross of California	3/99	24,920
		CP	Health Net	2/99	3,241

* Source for number of eligibles for all plans except FFS/MCN is the Monthly Medi-Cal Eligibility File.
** Source for FFS/MCN eligible counts is the Monthly Enrollment Report provided by the Managed Care Fiscal Monitoring Unit.
*** Healthy San Diego.

Table 1.3B, Major Managed Care Plans by County

Plan Name	Program	LI/CP	County	Enrollment* as of July 2000
Alameda Alliance for Health	2-PLAN	LI	**Alameda**	71,920
Blue Cross of California		TOTAL		262,802
	2-PLAN	CP	**Alameda**	27,830
	2-PLAN	CP	**Contra Costa**	4,823
	2-PLAN	CP	**Fresno**	23,416
	2-PLAN	CP	**Kern**	27,269
	GMC		**Sacramento**	57,274
(formerly OMNI)	GMC		**Sacramento**	15,728
	GMC		**San Diego*** **	10,564
	2-PLAN	CP	**San Francisco**	14,628
		CP	**Santa Clara**	23,036
	2-PLAN	LI	**Stanislaus**	33,314
	2-PLAN	LI	**Tulare**	24,920
CalOPTIMA	COHS		**Orange**	218,649
Central Coast Alliance For Health		TOTAL		64,244
	COHS		**Monterey**	43,019
	COHS		**Santa Cruz**	21,225
Community Health Group	GMC		**San Diego*** **	63,942
Contra Costa Health Plan	2-PLAN	LI	**Contra Costa**	38,277
Health Net		TOTAL		532,692
	2-PLAN	CP	**Fresno**	106,509
	2-PLAN	CP	**Los Angeles**	389,783
	GMC		**Sacramento**	26,576
	GMC		**San Diego*** **	6,583
	2-PLAN	CP	**Tulare**	3,241
Health Plan of San Joaquin	2-PLAN	LI	**San Joaquin**	48,288
Health Plan of San Mateo	COHS		**San Mateo**	37,707
Inland Empire Health Plan	2-PLAN	LI	**Riverside**	74,396
Inland Empire Health Plan	2-PLAN	LI	**San Bernardino**	102,332

Table 1.3B, Major Managed Care Plans by County (continued)

Plan Name	Program	LI/CP	County	Enrollment* as of July 2000
Kaiser Foundation	TOTAL			27,377
	GMC		**Sacramento**	19,565
	GMC		**San Diego*** **	7,812
Kern Health Systems	2-PLAN	LI	**Kern**	48,162
LA Care Health Plan	2-PLAN	LI	**Los Angeles**	586,960
Maxicare	GMC		**Sacramento**	19,302
Molina	TOTAL			56,054
	2-PLAN	CP	**Riverside**	22,926
	GMC		**Sacramento**	1,806
	2-PLAN	CP	**San Bernardino**	31,322
OMNI Healthcare	TOTAL			11,781
	2-PLAN	CP	**San Joaquin**	0
	2-PLAN	CP	**Stanislaus**	11,781
Partnership Health Plan of Calif.	TOTAL			47,858
	COHS		**Napa**	7,923
	COHS		**Solano**	39,935
Placer County Managed Care Network	FFS/MCN		**Placer****	10,674
San Francisco Health Plan	2-PLAN	LI	**San Francisco**	22,870
Santa Barbara Regional Health Authority	COHS		**Santa Barbara**	40,753
Santa Clara Family Health Plan	2-PLAN	LI	**Santa Clara**	36,967
Sharp Health Plan	GMC		**San Diego*** **	42,480
Sonoma County Managed Care Network	FFS/MCN		**Sonoma****	24,619
UCSD Healthcare	GMC		**San Diego*** **	11,934
Universal Care	GMC		**San Diego*** **	10,951
Western Health Advantage	GMC		**Sacramento**	15,295

* Source for number of eligibles for all plans except FFS/MCN is the Monthly Medi-Cal Eligibility File.
** Source for FFS/MCN eligible counts is the Monthly Enrollment Report provided by the Managed Care Fiscal Monitoring Unit.
*** Healthy San Diego.

Table 1.4, Aid Category Groups by FFS and Managed Care – Sacramento GMC, Two-Plan, and COHS Counties

The following pie chart shows the distribution of Medi-Cal beneficiaries broken out by managed care enrollment vs. fee-for-service and mandatory vs. voluntary/other aid category group, for counties partially or fully implemented to managed care as of July 2000. (See Table 1.5 for a list of these counties.) As this indicates, the percent of those in managed care is 55.4% for all aid categories, a 2% decrease since July 1999 (see the Managed Care Annual Statistical Report published March 2000, available on the Internet at http://www.dhs.ca.gov/MCSS). (See Appendix, Table A.1 for definitions of the aid category groupings.)

Source of these data is the July 2000 month of eligibility Medi-Cal Eligibles File using a four-month lag.

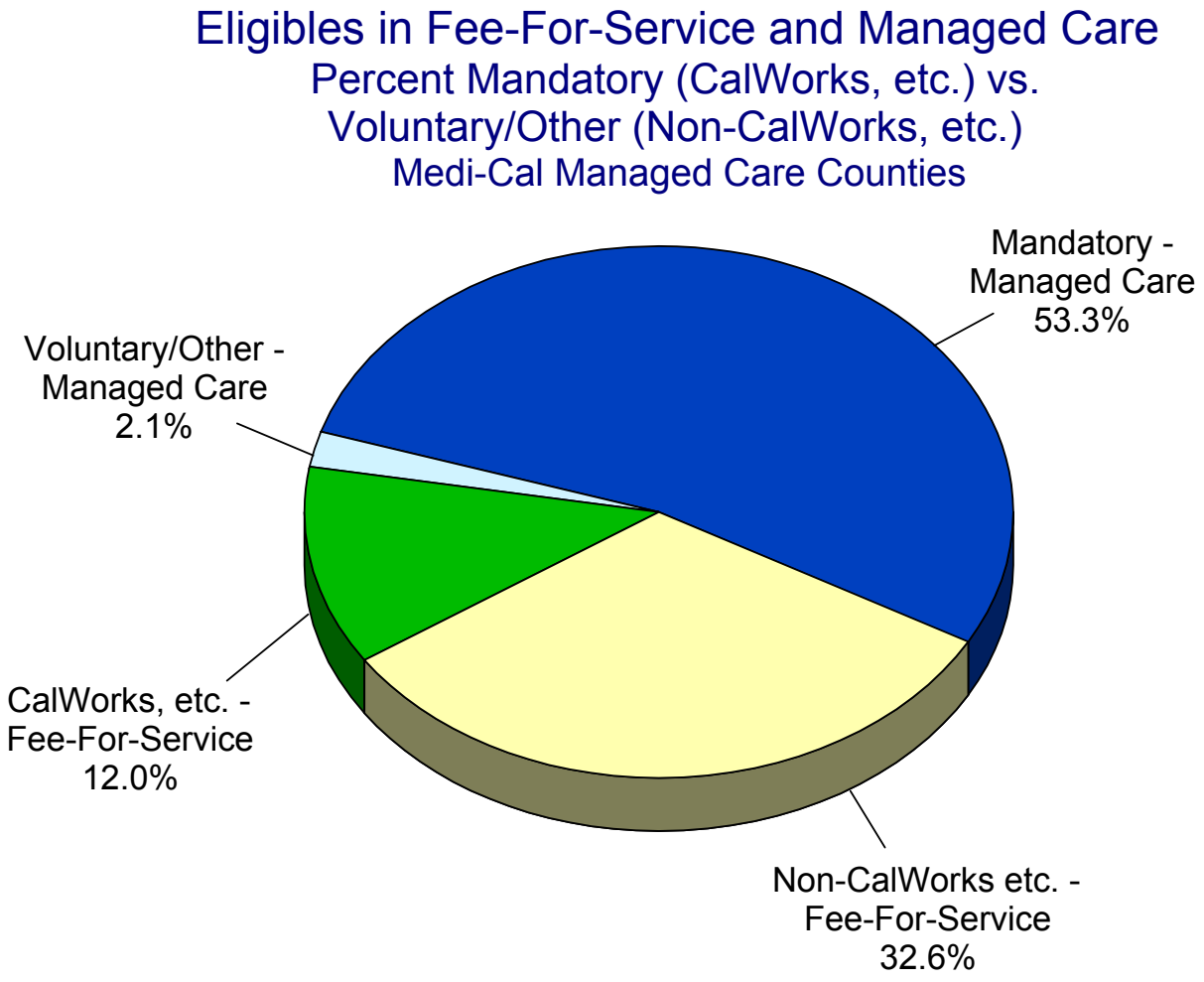
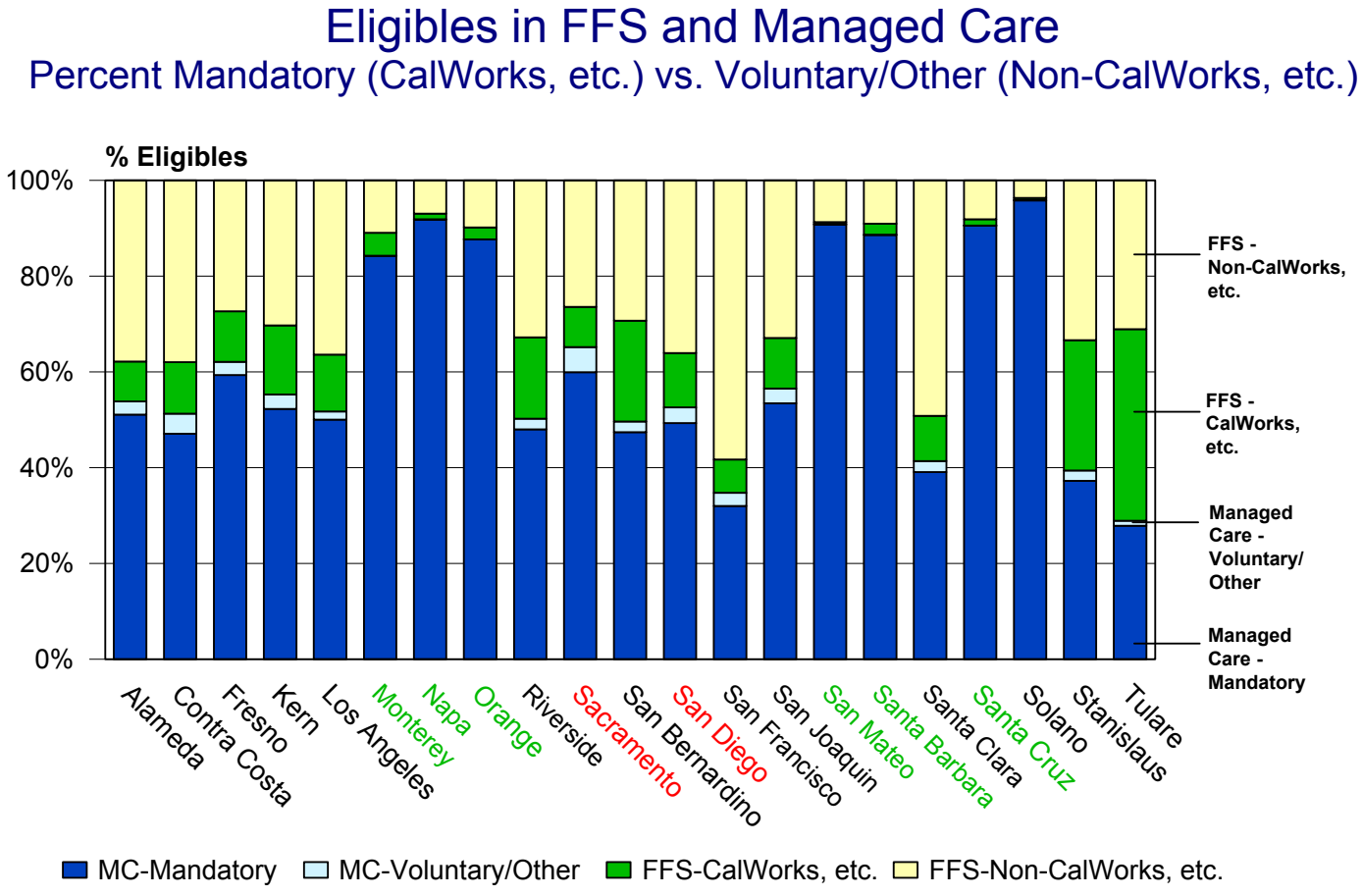


Table 1.5, Aid Category Groups by FFS and Managed Care – Sacramento GMC, Two-Plan, and COHS Counties

The following bar chart provides the distribution of Medi-Cal beneficiaries broken out by managed care enrollment vs. fee-for-service and mandatory vs. voluntary/other aid category group, for counties partially or fully implemented to managed care as of July 2000. As the chart shows, in most counties over half of these beneficiaries are in managed care. (See Appendix, Table A.1 for definitions of the aid category groupings.)

Source of these data is the July 2000 month of eligibility Medi-Cal Eligibles File using a four-month lag.



Two-Plan: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare counties.
COHS: Monterey, Napa, Orange, San Mateo, Santa Barbara, Santa Cruz, and Solano counties.
GMC: Sacramento & San Diego counties.

Table 1.6, Percent Mandatory Eligibles in Managed Care of All Mandatory Eligibles, Two-Plan Model Counties Only

Of those eligibles in a mandatory aid category, the following chart shows the percent of those actually enrolled in a managed care plan. The average by county enrollment of mandatory aid code eligibles in the Two-Plan Model and Geographic Managed Care Counties has decreased by 4.7% for implemented counties since July 1999 (see the Managed Care Annual Statistical Reports published March 2000, available on the Internet at http://www.dhs.ca.gov/MCSS). The month of eligibility for these data is July 2000 month of eligibility using a four month lag.

The percent of those in a mandatory aid category is always less than 100%. This is because, even though a beneficiary is in a mandatory aid category, they will not necessarily end up in a managed care plan. Reasons for this include: 1) managed care implementation is still in process; 2) the beneficiary received Medi-Cal eligibility retroactively (that is, between the start of the eligibility month and up to four months later); 3) the beneficiary has other health coverage (usually, CHAMPUS, Medicare HMO, Kaiser, or some PHP/HMO and EPO coverage) that excludes them from enrolling in a plan; 4) the beneficiary just became eligible for Medi-Cal in a particular county, and is still in the process of selecting a plan or will be defaulted into one; 5) the beneficiary lives in an exempted zip code; 6) the beneficiary has a medical exemption granted by the DHS (for a complete list of these exemptions, contact the DHS Medi-Cal Managed Care Division); 7) a person born to a mother on managed care is covered under fee-for-service the month of delivery and the following month, and then is put into managed care only after the legal guardian(s) successfully completes the Medi-Cal enrollment process (usually three to six months after birth); 8) a person switches from a non-mandatory to a mandatory aid code and is still in the process of selecting a plan.

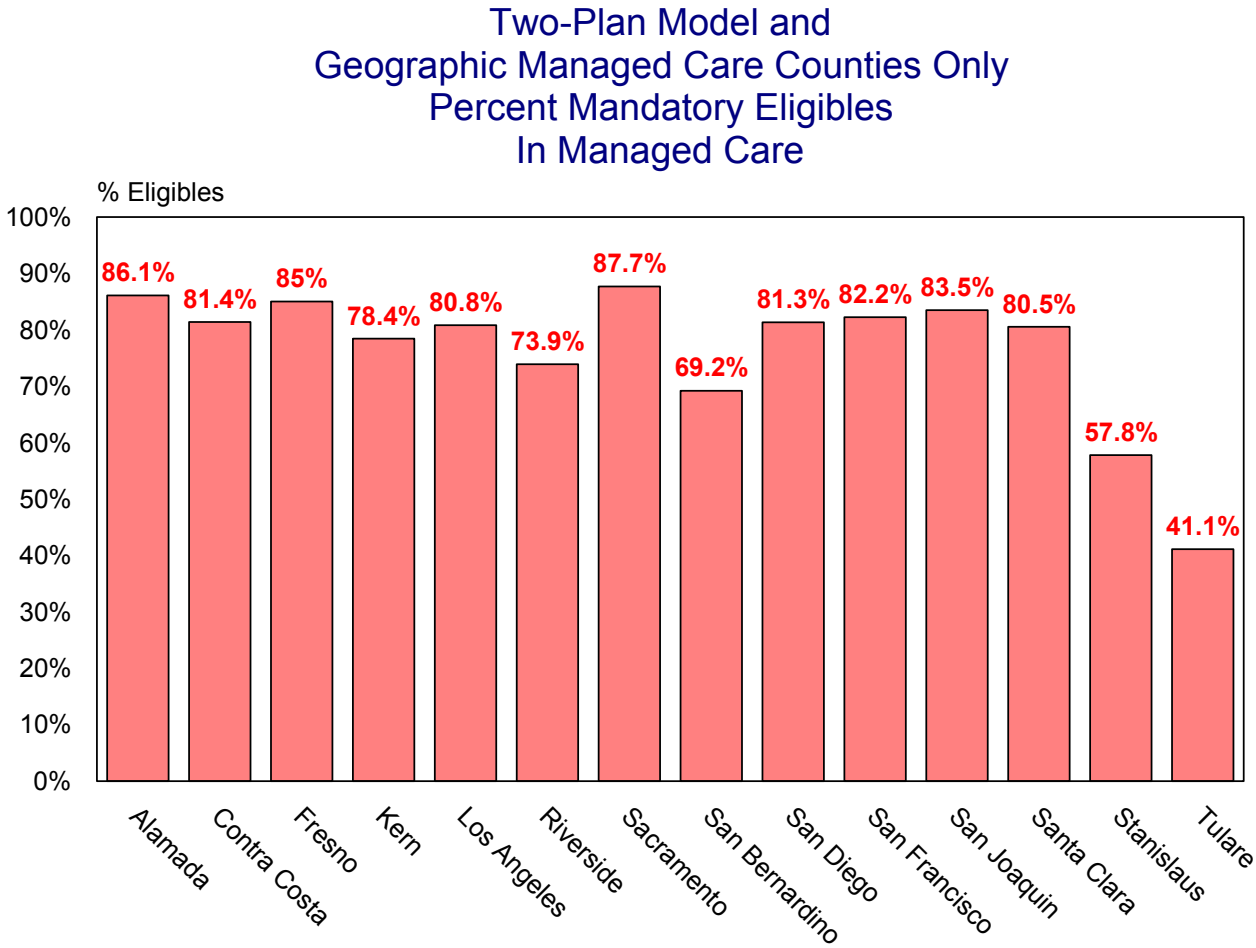


Table 1.7, Enrollment for Two-Plan Counties

The Two-Plan model counties are fully implemented as of July 2000. The following charts depict enrollment by county for the Commercial Plan vs. the Local Initiative for June 2000. As these show, in most cases, the Local Initiative has more Medi-Cal beneficiaries than the Commercial Plan. On a statewide basis, the Local Initiative plans have about two members for every one in the Commercial Plans. This may be explained by the fact that the Local Initiative usually started up before the Commercial Plan.

(Note: The Fresno county model has two Commercial Plans and no Local Initiative. Stanislaus county has had one Local Initiative since March 2000, when the Commercial Plan ceased operations.

Eligible counts used here were taken from computer-based eligibility files. Counts are slightly different from those shown in the Medi-Cal Managed Care Division's Monthly Enrollment Summary Report, usually because the computerized data base posts retroactive counts to the actual month of eligibility rather than rolling up all past activity at a point in time to the current report.

Source of these data is the June 2000 month of eligibility Medi-Cal Eligibles File using a six-month lag.)

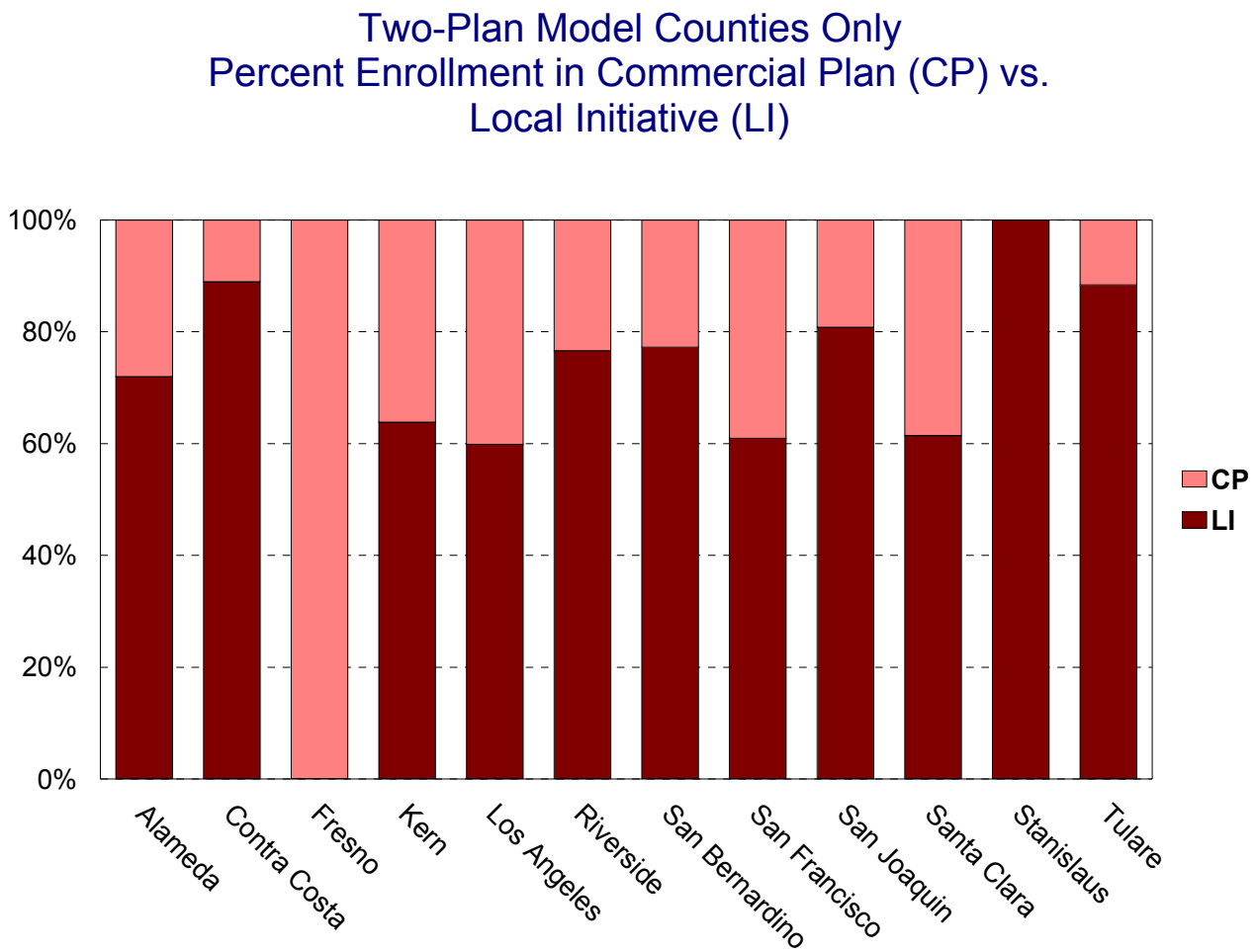


Table 1.8, Enrollment for GMC Counties

The following charts depict enrollment by county for the individual Geographic Managed Care (GMC) health plans for January 1996 through June 2000.

Average enrollment for most Sacramento GMC plans (Maxicare, Omni, Kaiser, Health Net, and Western Health) has been about 20,000 since July. Together these five plans enroll about 70% of all Sacramento GMC beneficiaries. Blue Cross has seen a steady increase in enrollment during the same time period, from 38,322 (28% of the Sacramento GMC population) in July 1997 to 56,903 (37%) in June 2000.

Three Sacramento GMC plans, River City, Healthreach, and UCD, were deactivated in April 1996, July 1999, and May 1997, respectively. The Medi-Cal beneficiaries in those plans were enrolled into Health Net (from River City), Maxicare (from Healthreach), and Western (from UCD). In early 2000, members from Omni Health Plan were transferred to Blue Cross Health Plan.

The Healthy San Diego GMC plans started in July 1998 with five fully capitated Prepaid Health Plans (PHP's) already operating in San Diego county. Three more plans were added in August 1998.

(Note: Eligible counts used here were taken from computer-based eligibility files using a six-month lag. Counts are slightly different from those shown in the Medi-Cal Managed Care Division's Monthly Enrollment Summary Report, usually because the computerized data base posts retroactive counts to the actual month of eligibility rather than rolling up all past activity at a point in time to the current report.)

Table 1.8, Enrollment for GMC Counties (continued)

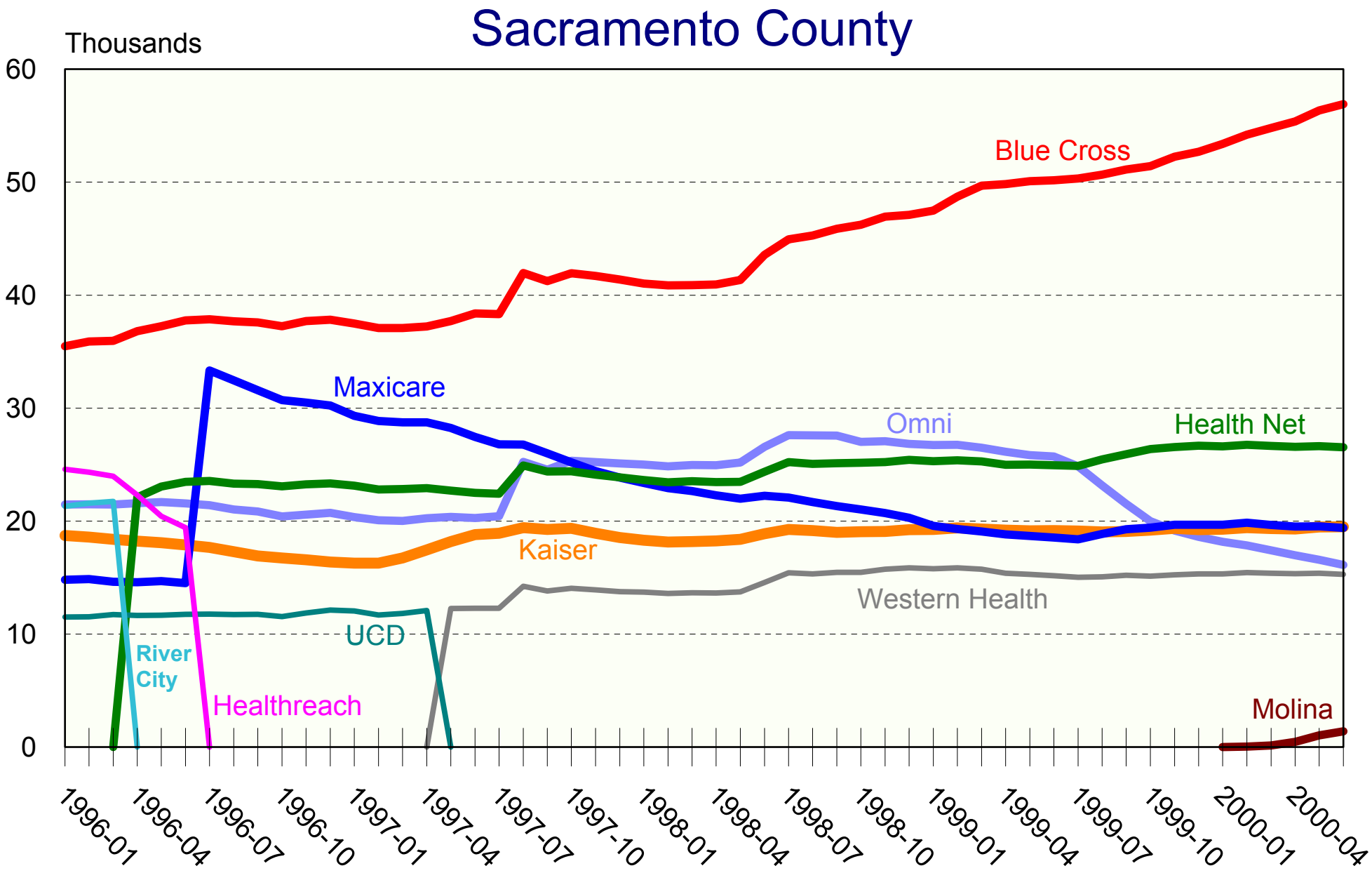
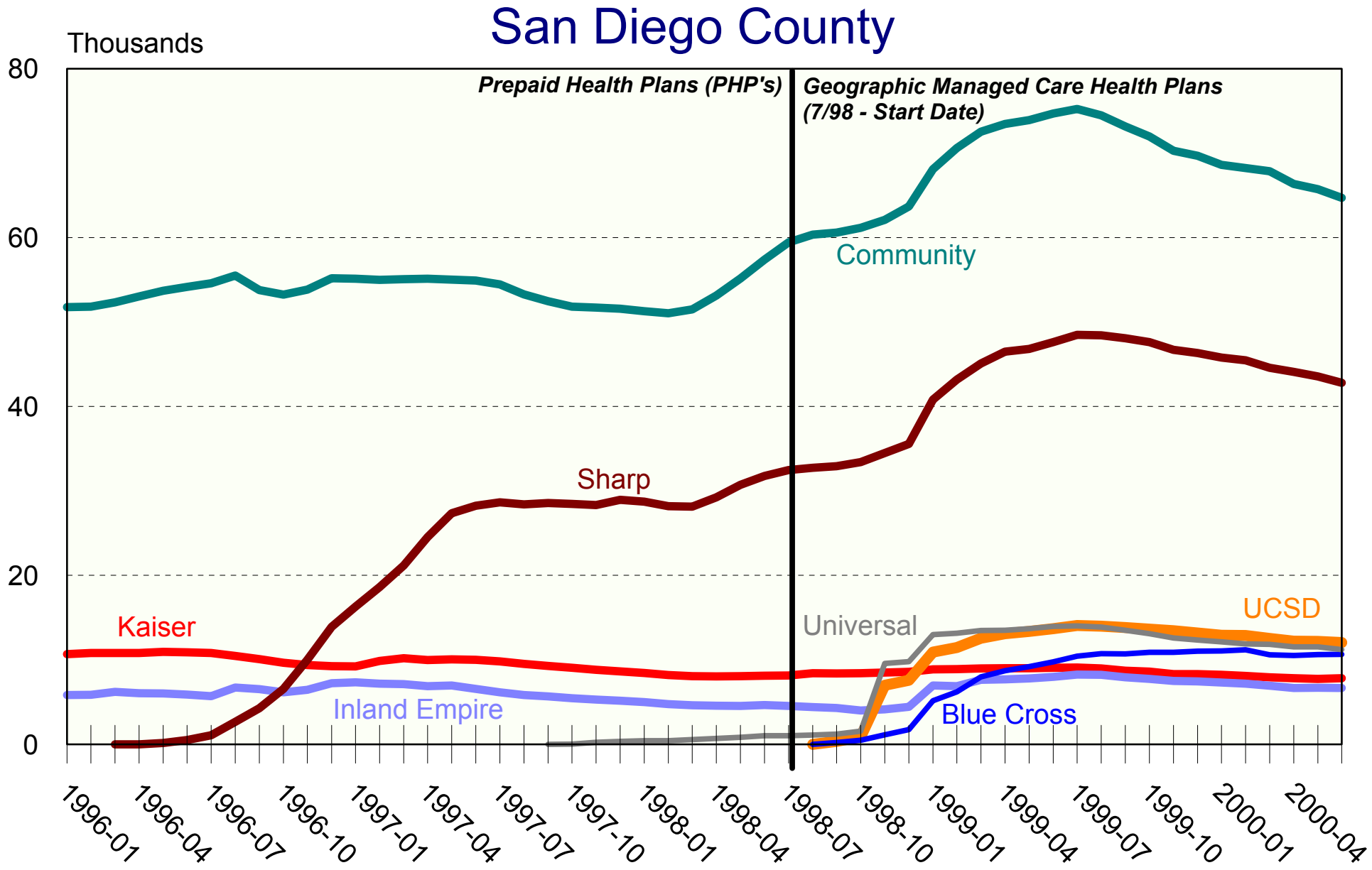


Table 1.8, Enrollment for GMC Counties (continued)



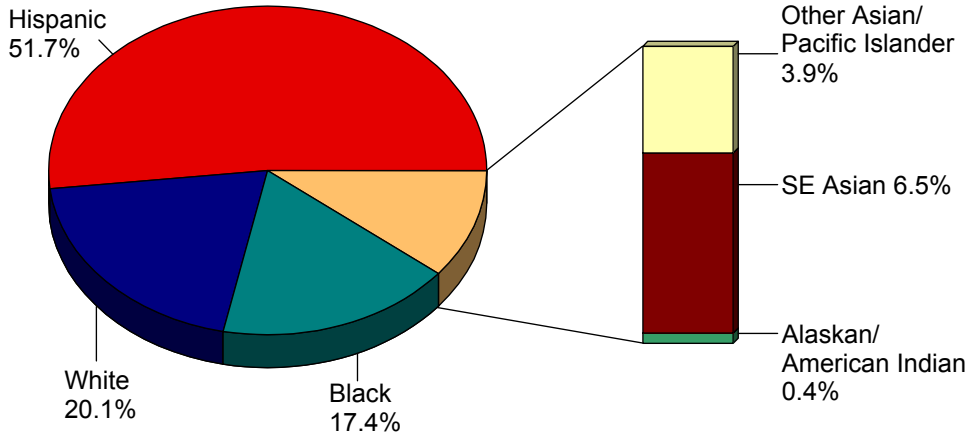
Section 2, Demographic Characteristics

Table 2.1, Breakout of Eligibles by Major Ethnic Groups

The following charts show a distribution of the Medi-Cal eligible population in managed care (GMC and Two-Plan) counties by major ethnic category. The first chart shows this breakout for the population considered Mandatory under the Two-Plan model (CalWorks, etc.). The second chart covers those not in a GMC or Two-Plan Mandatory (CalWorks, etc.) aid category group.

Source of these data is the July 2000 month of eligibility Medi-Cal Eligibles File using a four-month lag.

Mandatory (CalWorks, etc.) Eligibles



Non-Mandatory (Non-CalWorks, etc.) Eligibles

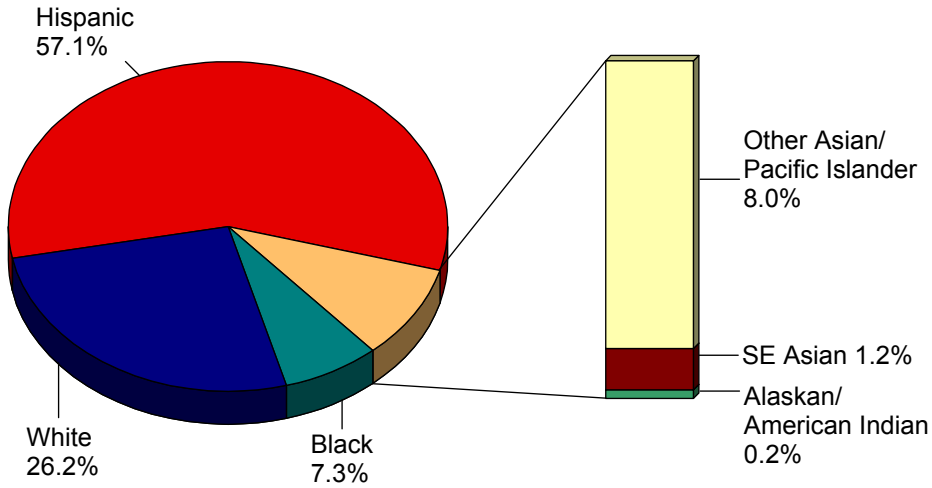
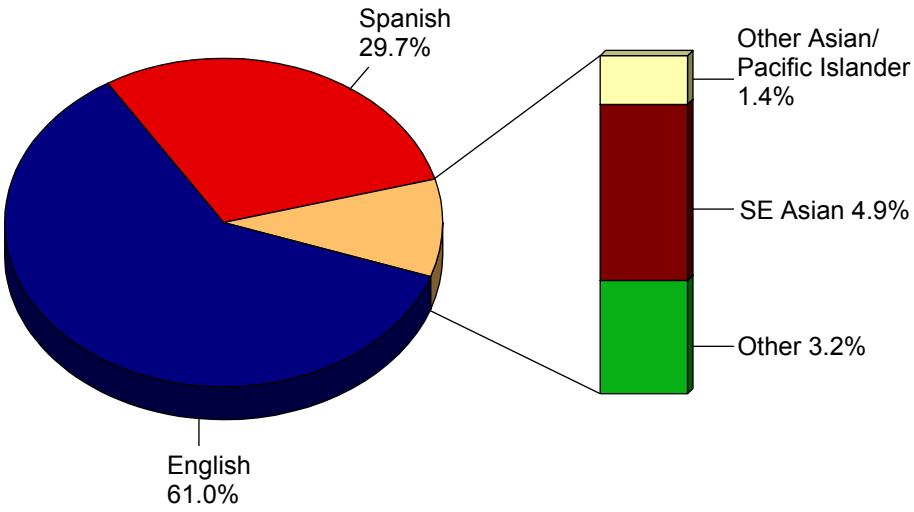


Table 2.2, Breakout of Eligibles by Major Language Category

The following charts show a distribution of the Medi-Cal eligible population in managed care (GMC and Two-Plan) counties by major language category. The first chart shows this breakout for the population considered Mandatory under the Two-Plan model (CalWorks, etc.). The second chart covers those not in a GMC or Two-Plan Mandatory (CalWorks, etc.) aid category group.

Source of these data is the July 2000 month of eligibility Medi-Cal Eligibles File using a four-month lag.

Mandatory (CalWorks, etc.) Eligibles



Non-Mandatory (Non-CalWorks, etc.) Eligibles

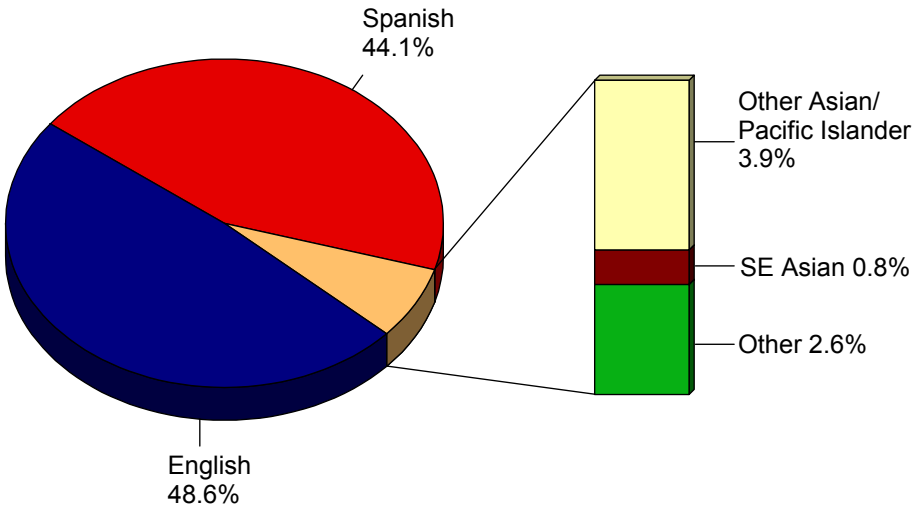


Table 2.3, Enrollment by Age and Gender for Two-Plan and GMC Plan Beneficiaries

In understanding the medical needs of the Medi-Cal population, it is helpful to know their distribution by age, gender and coverage by fee-for-service vs. managed care. Charts by age and gender were provided in the Managed Care Annual Statistical Report Published March 2000 (see Table 2.3). The chart below provides a breakout of those enrolled in managed care, by age and gender, for the Two-Plan and GMC counties for all aid codes. (Note: These data are from the July 2000 month of eligibility using a four-month lag; all ages are rounded off.)

This chart illustrates that a low percentage (45%) of the kids up to twelve months of age residing in a Two-Plan/GMC county are in managed care. This is primarily due to the high rate of retroactive beneficiaries. As mentioned in the narrative for Table 1.6, beneficiaries who are retroactive are not put into these types of managed care plans. The chart also illustrates that the percent of those in a managed care plan remains stable for the female population, but rises briefly (to 67%) for eighteen-year-old males before declining to a more stable 32.5% for twenty-two year olds. This sudden rise and drop is explained by the different rates of eligibility for the mandatory vs. the non-mandatory males for the age groups eighteen to twenty year olds.

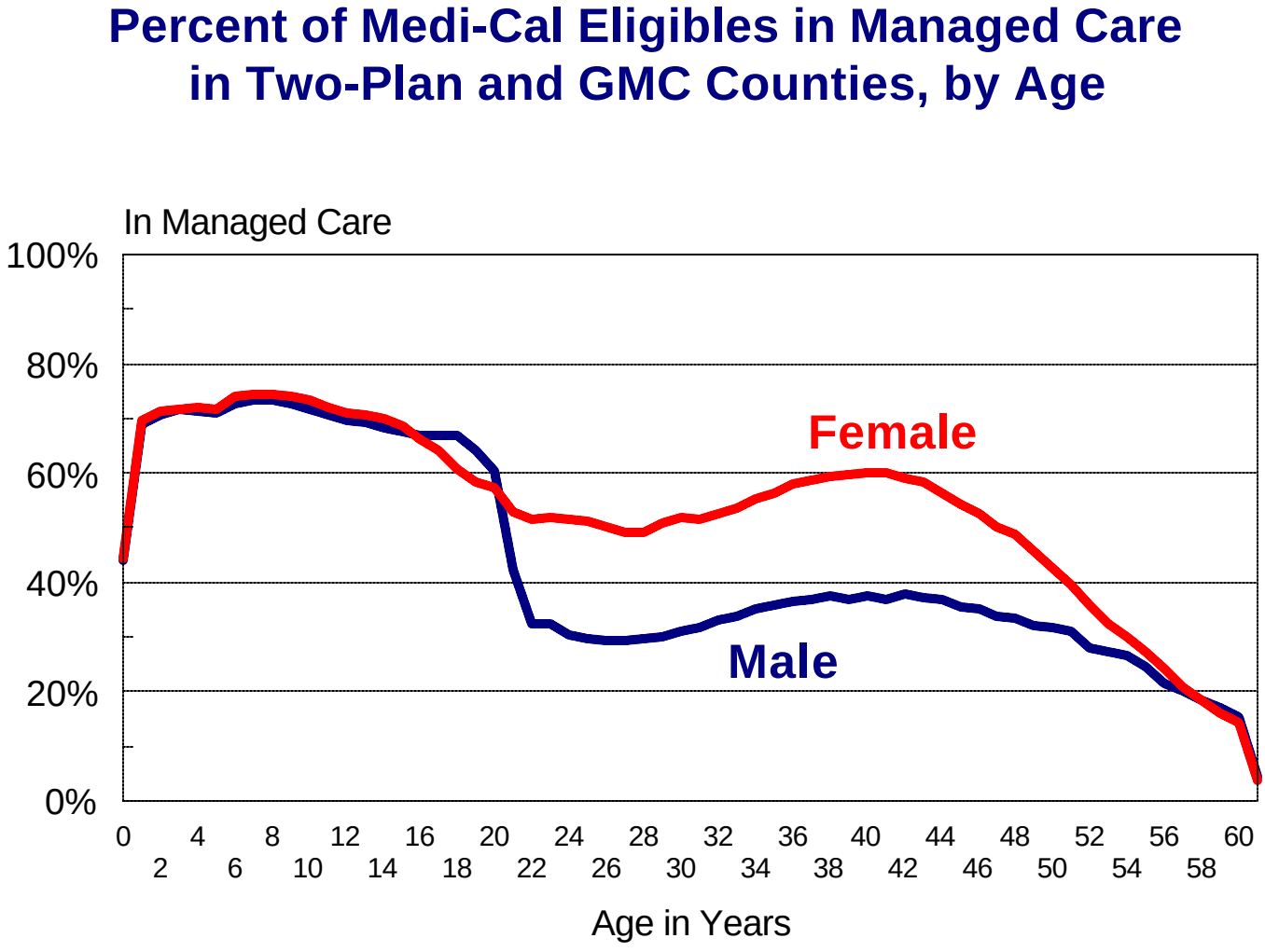


Table 2.4, Medi-Cal Eligibles in FFS vs. Managed Care in Two-Plan and GMC Counties, by Age

The following chart provides the number of beneficiaries in fee-for-service and managed care for the Two-Plan and GMC counties, by age in years. As reflected in Table 2.3, the number of males in both managed care and fee-for-service drops significantly at about 18 years of age. The number of males in managed care equals the number in fee-for-service at about age 21, whereas the number of females in managed care versus fee-for-service is about the same at age 48. The number of males on Medi-Cal is always less than females.

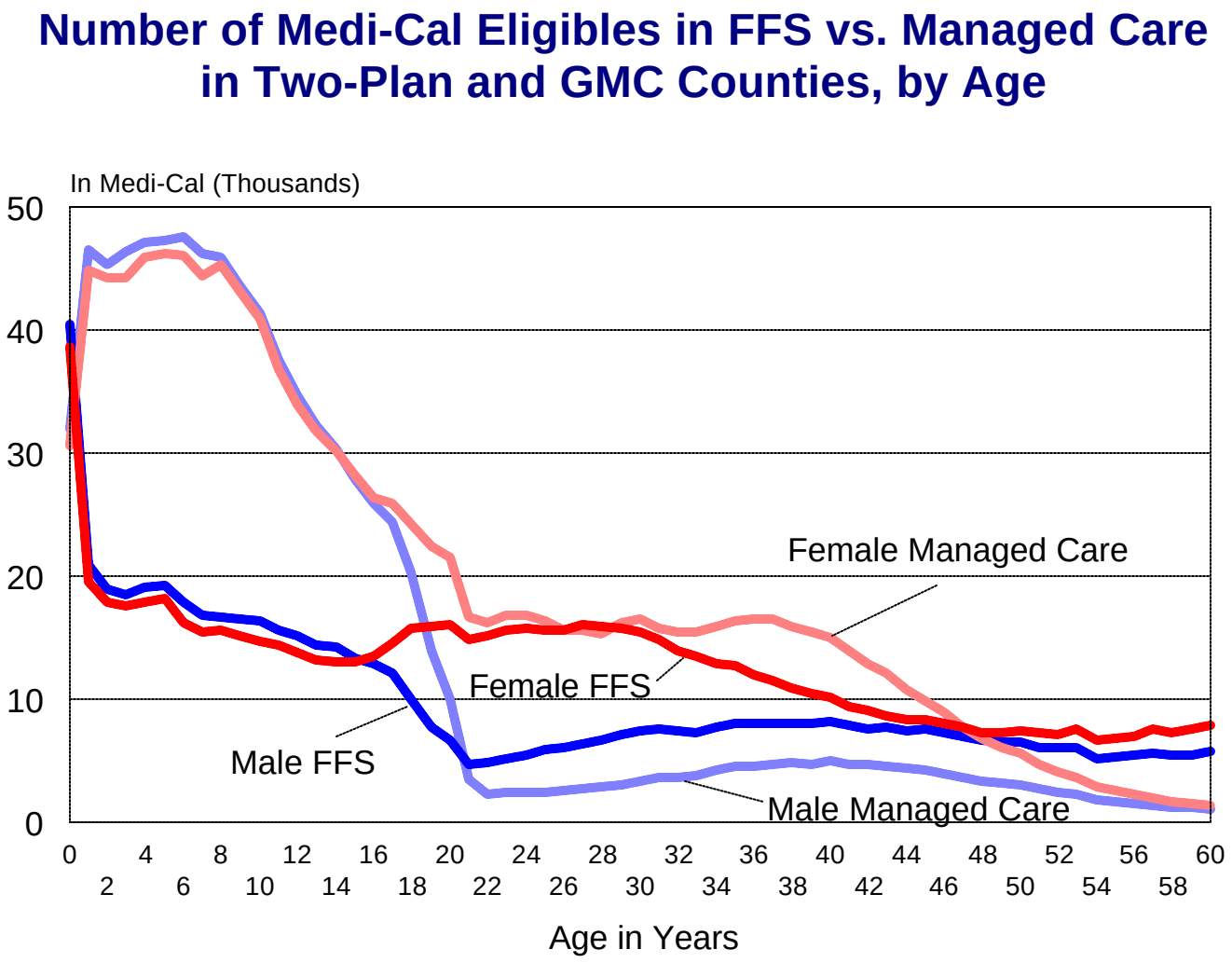
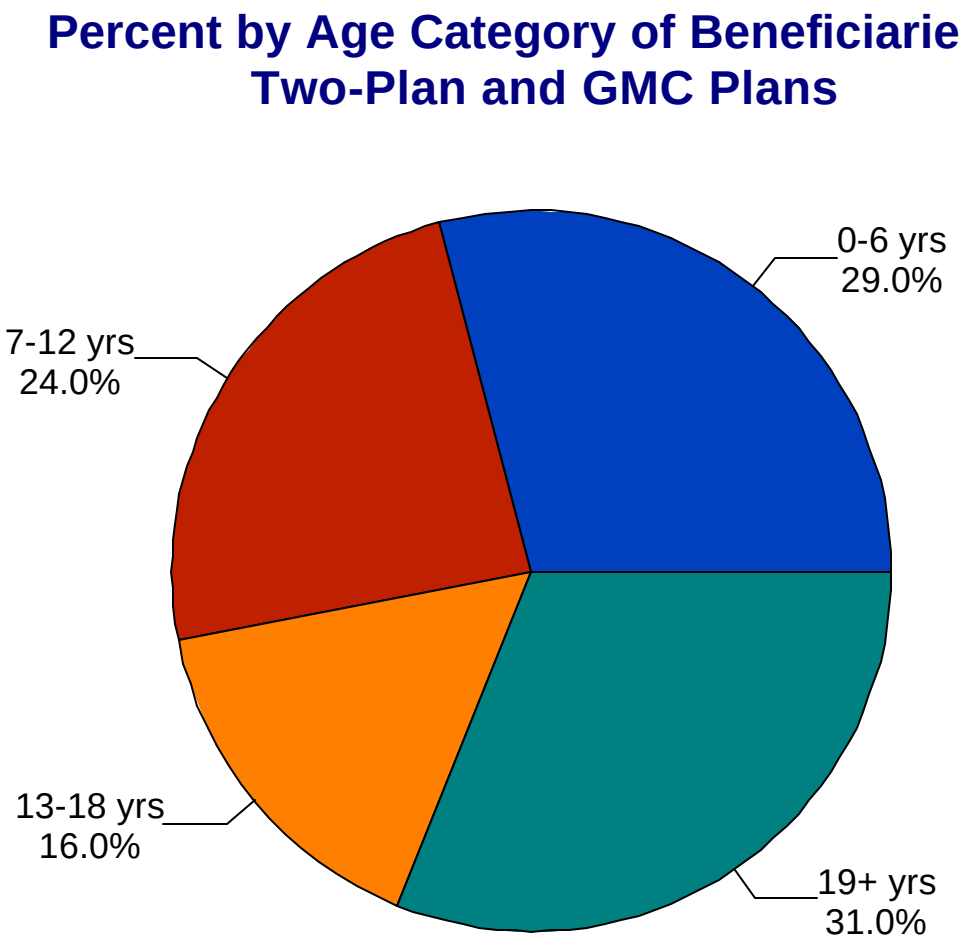


Table 2.5, Two-Plan and GMC Beneficiaries by Age Category

The following chart provides the number of beneficiaries in a Two-Plan or GMC plan by age, expressed as a percent. As this chart shows, less than a third of these beneficiaries are over 19 years of age or over, with almost a third six-years of age or less, and almost a quarter (24%) aged seven through twelve of years.



Section 3, Eligibility Continuity and Rate of New Eligibles

The length of time someone is on Medi-Cal is an important factor in the provision of medical services under managed care. The longer and more continuously a person is enrolled in a managed care plan, the easier it should be for a beneficiary to receive preventive and continuous care. Other benefits include the development of a closer relationship between the primary care physician and the beneficiary and less administrative cost to the plan. One way to measure duration of eligibility is to determine how long individual beneficiaries are continuously Medi-Cal eligible. Tables 3.1 and 3.2 provide rates of continuous eligibility for a recent period of time, without regard to a person's pre-existing eligibility.

This "continuity of eligibility" methodology was then applied to the mandatory aid category population for those counties that had implemented Two-Plan and GMC managed care plans. Separate rates were developed for eligibles who stayed in a managed care plan. These rates are shown in Table 3.3.

Another useful measure of the stability of the Medi-Cal population in terms of eligibility is the rate at which new eligibles go on Medi-Cal. One measure of this is the number of eligibles moving from ineligibility to eligibility status, expressed as a percent of all eligibles. This rate was derived for all eligibles as well as just the managed care mandatory aid category population, and is depicted in Tables 3.4 and 3.5.

Note: The information used to construct Tables 3.1 through 3.3 were derived from a longitudinal database for a five percent sample of all Medi-Cal beneficiaries, created and maintained by the Medical Care Statistics Section.

Table 3.1, Continuity of Eligibility in Aggregate

The following chart shows how long a beneficiary would tend to remain eligible for Medi-Cal over a three-year period. The chart reflects eligibility trends as they existed during CY97 through CY99.

To establish the rates shown below, each beneficiary in our database was tracked for thirty-six months, regardless of their eligibility status in the month immediately preceding the period. Any break in eligibility would drop an eligible from being counted at that point. (Studies have shown only a slight difference in the percent continuously eligible when a one-month break is allowed in the definition.)

The curve labeled "Aggregate" shows the rate at which a person who was eligible for Medi-Cal in the first month is likely to remain on Medi-Cal each month for up to thirty-six months. The chart shows that 72% of this population will likely still be on Medi-Cal after the first year, 59% after two years, and 50% at three. If this population were categorized into seven relatively homogenous eligibility groups, the rate of continuous eligibility for all these beneficiaries (staying within their assigned group) is shown in the chart as "Aggregate – All Groups." (The difference between the curves is the population who were continuously eligible, but who moved from one eligibility group to another.)

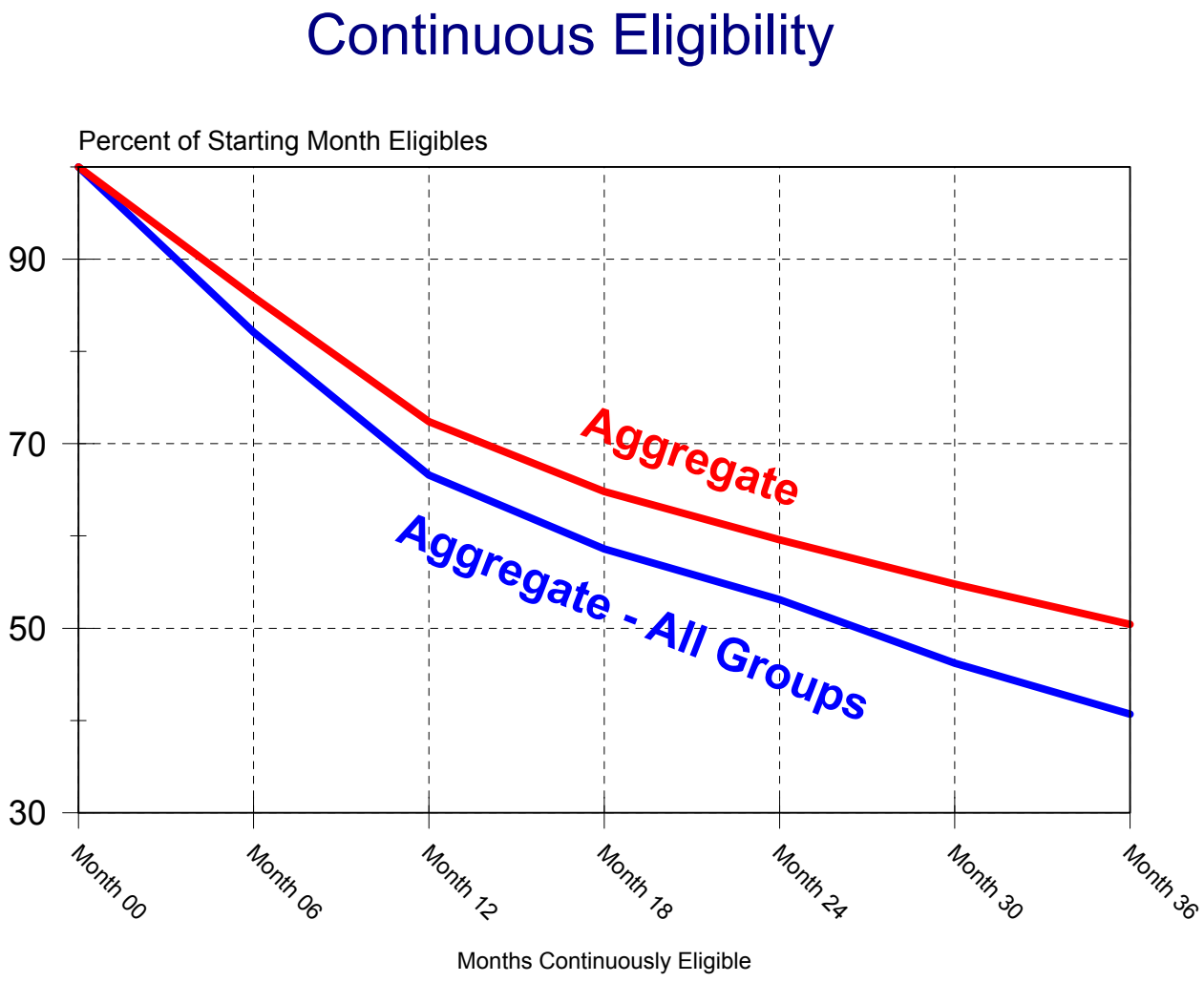


Table 3.2, Continuity of Eligibility by Major Aid Category Group

The following chart is similar to Table 3.1, except that eligibles were classified into distinct eligibility groups. Each curve represents those eligibles who continuously belonged to an assigned group for the months shown. If a Medi-Cal eligible either ceased being eligible, or changed to another aid category within this time period, they are excluded from the curve within that six-month period.

It is important to note that this table includes anyone who was eligible the first month of this thirty-six month time frame without regard to their eligibility status in Month 00. A subset of this population is one in which persons were not on Medi-Cal in Month 00, the month prior to the period being considered here. For those interested in this topic, please refer to Table 3.3, Continuity of Eligibility for AFDC – Cash Grant, the Managed Care Annual Statistical Report published April 1999.

The major groups shown in the chart are: 1. SSI/SSP; 2. Long Term Care; 3. Cal-Works; 4. Medi-Cal only, Families, No SOC; 5. Medi-Cal only, Aged Blind, Disabled, no share of cost; 6. Share of cost; 7. Miscellaneous. (For a listing of the aid categories making up each of these groupings, refer to the Appendix, Table A.2.)

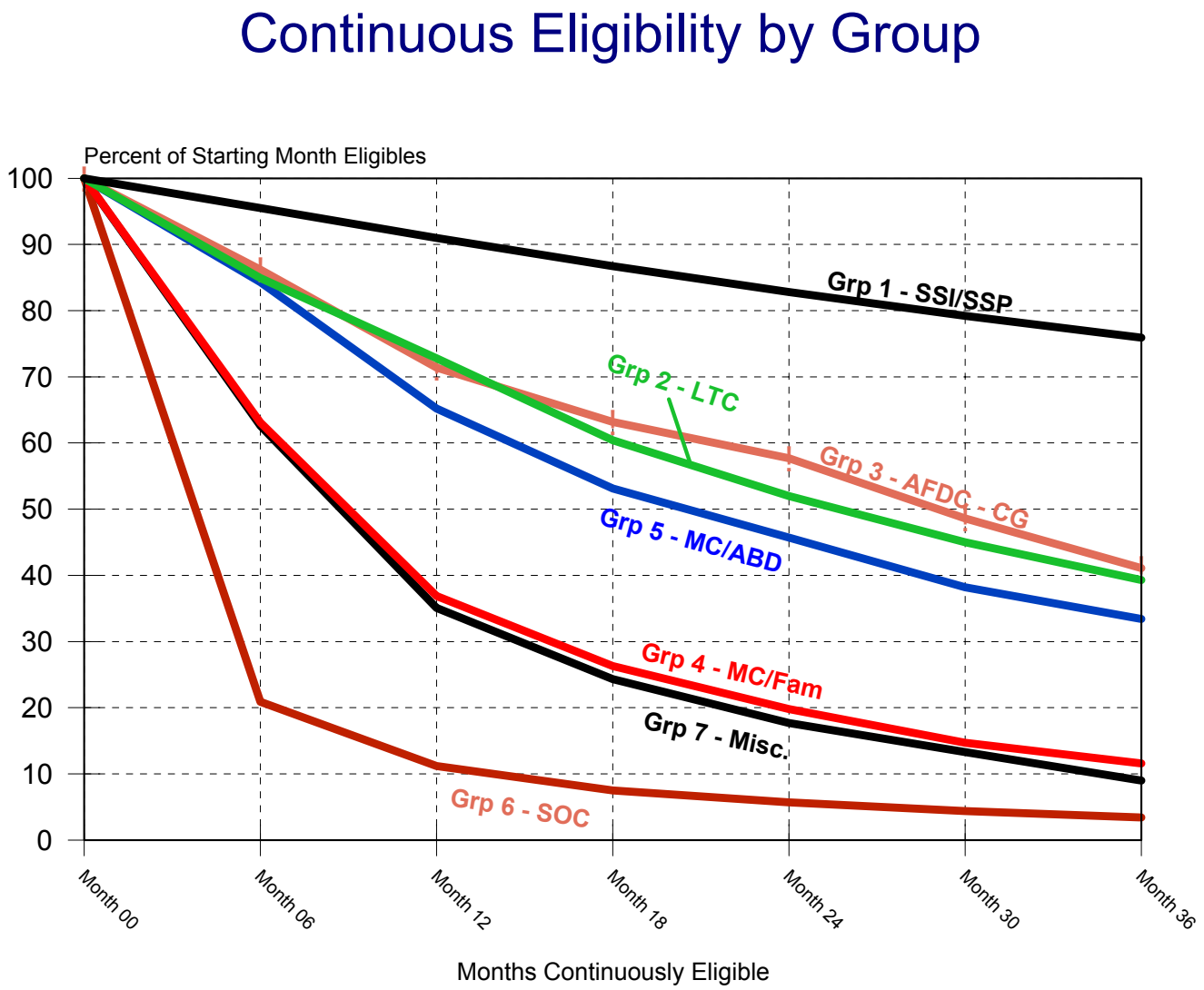


Table 3.3, Continuity of Enrollment for Two-Plan County Plans

The rate at which persons in mandatory aid codes will be continuously enrolled in a managed care plan will always be less than those on Medi-Cal in a mandatory aid code. The difference in the rates may be attributable to such factors as switching enrollment from one plan to another, moving from one county to another, or obtaining a medical exemption to obtain services under fee-for-service. The following chart shows these rates for the period July 1998 through December 1999 for fully implemented Two-Plan counties. (The methodology applied here is similar to that used for Table 3.2; the rate is for a population of eligibles who may or may not have been eligible prior to July 1998 within the same managed care counties used to create the enrollment rate.)

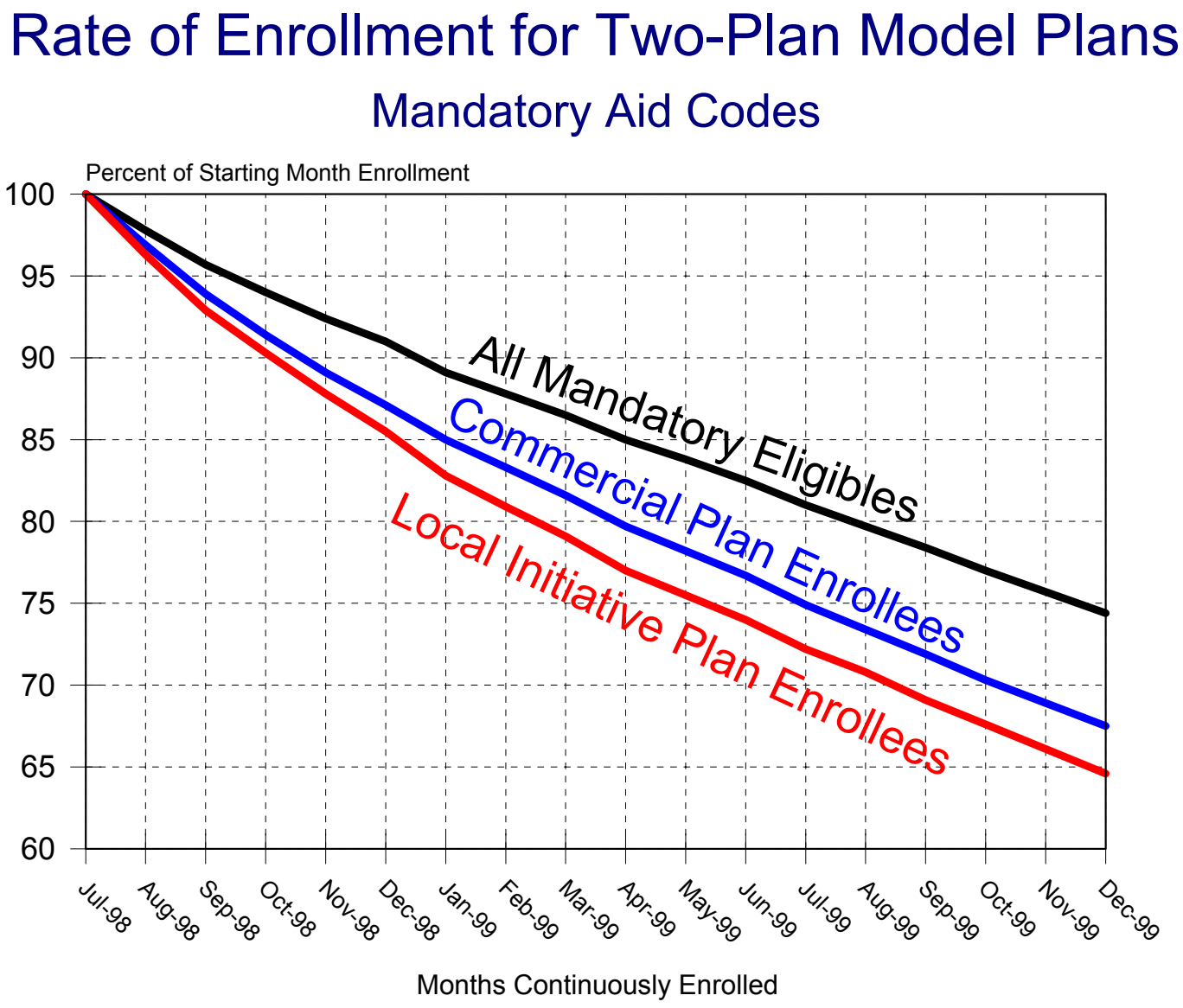


Table 3.4, Rate of "Six-Month" New Beneficiaries on Medi-Cal

As with continuity of eligibility, the rate at which beneficiaries become eligible for Medi-Cal provides some measure of the turnover of this population. As mentioned above, this in turn can have a direct impact on the quality of care provided under managed care. There are two approaches to looking at this turnover issue: one is to consider just those who are relatively new to Medi-Cal, the other is to look at those with only one month of ineligibility. The difference should be an approximation of those intermittently, that is, not continuously, enrolled in Medi-Cal.

The following chart shows the rate at which beneficiaries become eligible after being ineligible (not on Medi-Cal) for six months, i.e., the "new-to-Medi-Cal population." The percentages shown in this table were derived by first calculating a denominator of a count of eligibles for the months February, May, August, and November for the calendar years 1993 through 1999. A subset of this population, those ineligible the previous six months, was used to calculate a percent or rate of those "new" to Medi-Cal. The same methodology was used to develop a rate for the "mandatory" population, those most likely to be in a managed care plan in Two-Plan Model and GMC counties. (Note: To provide comparability of data, the same aid codes are defined as mandatory for all years, even though this definition has changed slightly over this period. For instance, using a current definition of mandatory aid codes, the rate is marginally higher.)

As information from this chart shows, the overall rate of new persons coming onto Medi-Cal dropped significantly from CY93 to CY97, then rose slightly or stayed the same over the next two years. One explanation may be that the effects of a strong economy in suppressing the rate of new eligibles had run its course by CY97. (Also see Excel Table 3.4, which accompanies this report.)

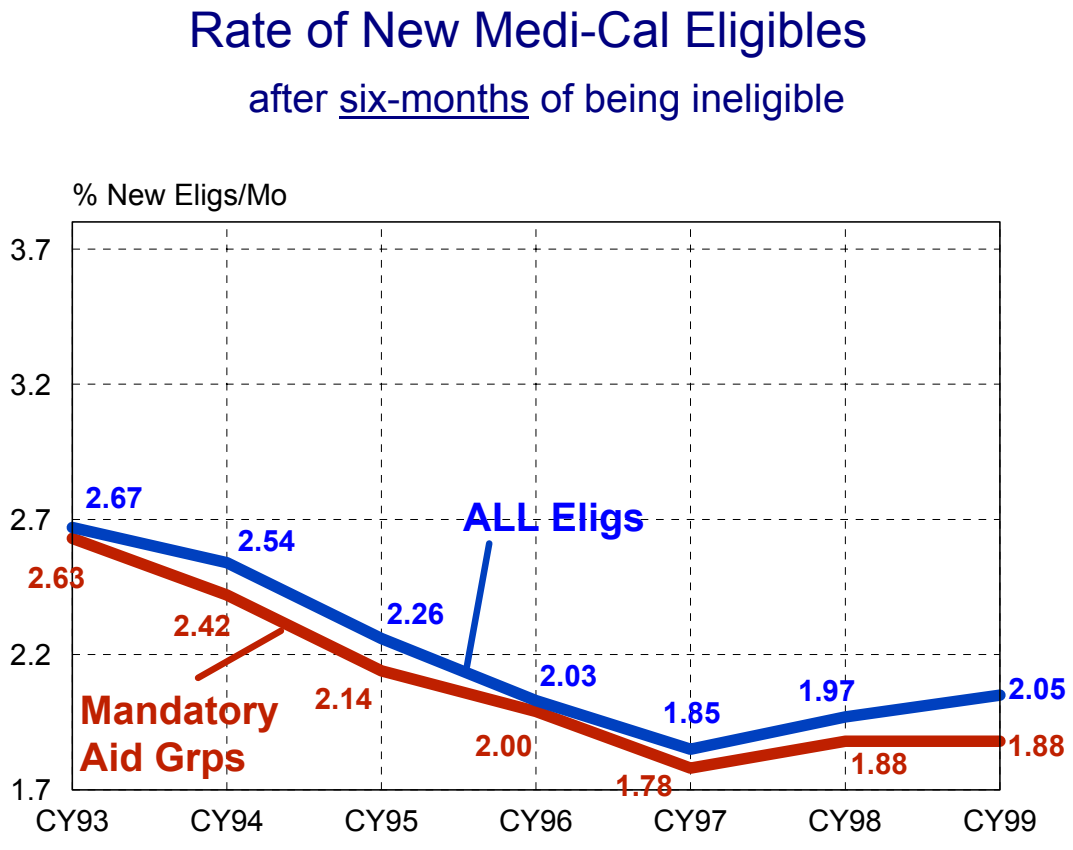
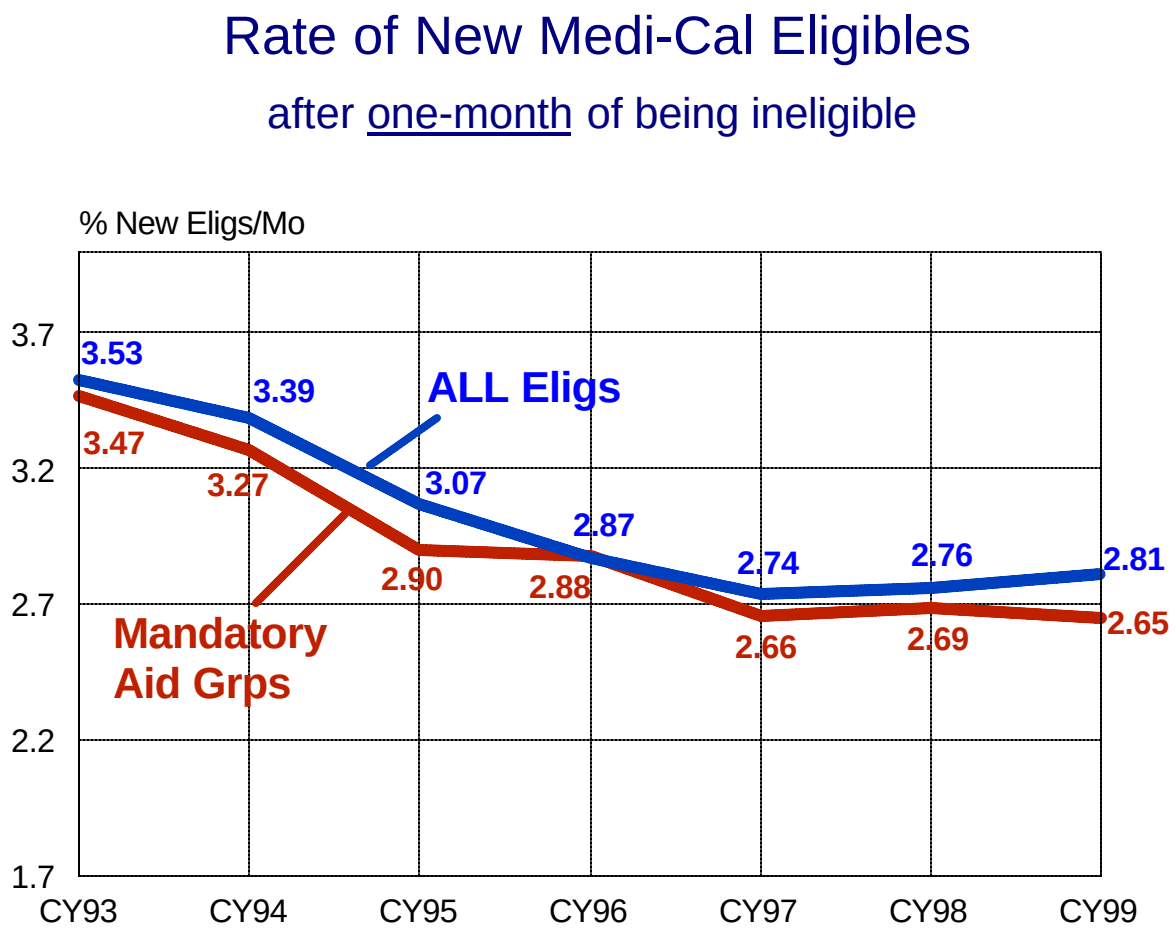


Table 3.5, Rate of "One-Month" New Beneficiaries on Medi-Cal

As the following chart indicates, when the definition of "new eligible" is relaxed from six months of ineligibility to one month, the percentages increase substantially. It is interesting to note that the rates of "One-Month" new eligibles has leveled off from CY97 forward.



Appendices

Appendix, Table A.1, List of Aid Categories by Managed Care Model and Type of Membership Status

The following table provides a list by aid categories, and which are considered mandatory (M), vs. voluntary (V), vs. other (o) (can't join) for each plan model. (Note: This table was current as of August 2000. For a current table, contact the DHS Medi-Cal Managed Care Division.)

	COHS		GMC		Two-Plan	FFS/ MCN	PHP/ PCCM
Aid Cat.	Monterey, San Mateo & Solano	Napa, Orange, Santa Barbara & Santa Cruz	Sacramento	San Diego			
0A	M	M	V	M	M	V	V
01	M	M	V	M	M	V	V
02	M	M	V	M	M	V	V
03	M	M	V	V	V	V	V
04	M	M	V	V	V	V	V
08	M	M	V	M	M	V	V
10	M	M	V	V	V	V	V
13	M	M	o	o	o	o	o
14	M	M	V	V	V	V	V
16	M	M	V	V	V	V	V
17	M	M	o	o	o	o	o
18	M	M	V	V	V	V	V
1A	M	M	V	V	V	V	V
20	M	M	V	V	V	V	V
23	M	M		o	o	o	o
24	M	M	V	V	V	V	V
26	M	M	V	V	V	V	V
27	M	M	o	o	o	o	o
28	M	M	V	V	V	V	V
30	M	M	M	M	M	M	V
32	M	M	M	M	M	M	V
33	M	M	M	M	M	M	V
34	M	M	M	M	M	M	V
35	M	M	M	M	M	M	V
36	M	M	V	V	V	V	V
37	M	M	o	o	o	o	o
38	M	M	M	M	M	M	V
39	M	M	M	M	M	M	V
3A	M	M	M	M	M	M	V
3C	M	M	M	M	M	M	V
3E	M	M	M	M	M	M	V
3G	M	M	M	M	M	M	V
3H	M	M	M	M	M	M	V
3L	M	M	M	M	M	M	V
3M	M	M	M	M	M	M	V
3N	M	M	M	M	M	M	V
3P	M	M	M	M	M	M	V
3R	M	M	M	M	M	M	V
3U	M	M	M	M	M	M	V
40	M	M	V	V	V	V	V
42	M	M	V	V	V	V	V
45	M	M	V	V	V	V	V
47	M	M	M	M	M	V	V
4A	M	M	V	V	V	V	V
4C	M	M	V	V	V	V	V

Appendix, Table A.1, List of Aid Categories by Managed Care Model and Type of Membership Status

	COHS		GMC		Two-Plan	FFS/ MCN	PHP/ PCCM
Aid Cat.	Monterey, San Mateo & Solano	Napa, Orange, Santa Barbara & Santa Cruz	Sacramento	San Diego			
4F	M	M	V	V	V	V	V
4G	M	M	V	V	V	V	V
4K	M	M	V	V	V	V	V
4M	M	M	V	V	V	o	V
53	M	M	o	o	o	o	o
54	M	M	M	M	M	M	V
55	M	o	o	o	o	o	o
58	M	o	o	o	o	o	o
59	M	M	M	M	M	M	V
5F	M	o	o	o	o	o	o
5K	M	M	V	V	V	V	V
5X	M	M	M	M	M	M	V
60	M	M	V	V	V	V	V
63	M	M	o	o	o	o	o
64	M	M	V	V	V	V	V
65	M	M	o	o	o	o	o
66	M	M	V	V	V	V	V
67	M	M	o	o	o	o	o
68	M	M	V	V	V	V	V
6A	M	M	V	V	V	V	V
6C	M	M	V	V	V	V	V
6G	M	M	V	V	V	V	V
6N	M	M	V	V	V	V	V
6P	M	M	V	V	V	V	V
6R	M	M	V	V	V	V	V
6V	M	M	V	V	V	V	V
6W	M	M	o	o	o	o	o
6X	M	M		o	o	o	o
6Y	M	M	o	o	o	o	o
72	M	M	M	M	M	V	V
7A	M	M	M	M	M	M	V
7X	M	M	M	M	M	M	V
81	M	M	o	o	o	o	o
82	M	M	M	M	M	V	V
83	M	M	o	o	o	o	o
84	o	o	o	o	o	o	M (Sonoma only)
86	M	M	V	V	V	V	V
87	M	M	o	o	o	o	o
88	o	o	o	o	o	o	M (Sonoma only)
8G	M	M	o	o	o	o	o
8P	M	M	M	M	M	V	V
8R	M	M	M	M	V	V	V

Appendix, Table A.2, List of Aid Categories Used For Section 3

Aid Code Category	Aid Codes
1. SSI/SSP	10, 18, 20, 28, 60, 68
2. Long Term Care	13, 23, 53, 63
3. Cal-Works-Cash Grant	30, 32, 33, 35, 38, 3A, 3C, 3P, 3R, 3G, 3H, 3E, 3L, 3M, 3U, 40, 42, 4C
4. Medi-Cal only, Families, No SOC	03, 04, 07, 3N, 3T, 3V, 34, 39, 4A, 4K, 4M, 44, 45, 47, 48, 49, 5K, 5M, 5T, 5W, 5X, 5Y, 54, 59, 69, 7A, 7C, 7F, 7G, 7M, 7N, 7P, 7R, 70, 72, 74, 75, 76, 79, 8N, 8P, 8R, 8T, 82, 86
5. Medi-Cal only, ABD, No SOC	14, 15, 16, 1H, 1U, 24, 26, 36, 64, 66, 6A, 6C, 6G, 6H, 6V, 6X
6. Share of Cost	17, 27, 37, 65, 67, 6Y, 6W, 83, 87
7. Miscellaneous	01, 02, 08, 0A, 51, 52, 55, 56, 57, 58, 5F, 5G, 5H, 71, 73, 7H, 80, 81, 8G